Chantal Cohen Therapy, LLC

Chantal Cohen, MA, LMFT
Phone: (907) 346-0252
FAX: (907) 202-5452 HIPPA Compliant

www.chantalcohentherapy.com

Request/Authorization to Release Confidential Records and Information

I hereby authorize: Chantal Cohen, MA, LMFT dba Chantal Cohen Therapy, LLC (Phone: (907) 346-0252 and FAX: (907) 202-5452 HIPPA Compliant) to release the following information:

Client:_____ DOB: _____

Social Security number: _____

To Be Release To: _____

Address:_____

Phone Number:_____ Fax Number:_____

Start Date:_____ **End Date**:_____

For the Following Purpose(s):

❑ Further mental health evaluation, treatment, or care ❑ Rehabilitation program development or services

❑ Treatment planning ❑ Legal ❑ Other: _____

Type of Communication

❑Verbal ❑Written

Information to be Released:

❑ Intake and Discharge Summaries ❑ Mental Health Assessments ❑ Treatment Plans

❑ Progress notes, and treatment or closing summary ❑ Other: _____

I understand this request/authorization to release records and information is voluntary. I understand the nature of this request, the records, their contents, and the likely consequences and implications of their release. I understand that I may revoke this voluntary consent at any time before the end date, not to exceed one year.

_____ _____ _____

Signature of client or guardian Printed name Date

_____ _____ _____

Signature of client or guardian Printed name Date

_____ _____

Signature of Therapist Date