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AUTHORIZATION & RELEASE OF INFORMATION

This Authorization & Release must be completely filled out

I, _____, give permission to Keri S. Cohen, LCSW, to obtain or release information to _____.

The information released or obtained will be for the sole purpose of diagnostic assessment, treatment, evaluation for services, prognosis, payment or health care operations, unless an additional purpose is described below (including Marketing, Sale of Information or Research): _____.

I authorize the request/disclosure of my information as checked below:

☐ Psychiatric and/or Psychological Evaluation

☐ Medical Records, including medication history and physician notes
□ Verbal Communication Only □ Written Information Only □ Verbal and Written Information

☐ Academic Records, Testing Results and Behavioral Information
□ Verbal Communication Only □ Written Information Only □ Verbal and Written Information

☐ Legal Information: Law Enforcement Agency, Attorney, Probation and Parole Office
□ Verbal Communication Only □ Written Information Only □ Verbal and Written Information

☐ Other: _____

_____.

Date Restrictions: _____.

I understand that the information in my health care record may include sensitive information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. This information will be disclosed unless I specify that the information not be disclosed by initialing below:

____Alcohol/Drug Abuse and/or Dependence _____Mental Health/Rehabilitation
____HIV and/or AIDS _____Sexual Assault

Read entire document before signing

This authorization gives Keri Cohen, LCSW permission to obtain or release information about you. Federal law requires a specific authorization to permit use or disclosure of psychotherapy notes, except to the extent such disclosure is specifically permitted by law.

Right not to sign. You may refuse to sign this authorization. Refusal to sign this authorization will not affect your ability for treatment. However, it has been explained that failure to sign this Authorization & Release may have the following consequence: disruption in continuity of care.

Right to revoke. You may revoke this authorization at any time except to the extent that we have relied on the authorization. To revoke this authorization, you must submit a written revocation to the following address:

Keri S. Cohen, LCSW
PO Box 4064
Lancaster, PA 17604

Re-disclosure. Information disclosed pursuant to this authorization may be subject to re-disclosure and may be no longer protected by the federal privacy rule or another privacy law, or by this Authorization & Release, with the exception that further disclosure of substance abuse information is prohibited unless expressly permitted by you in writing.

I have read and understand this Authorization & Release, and authorize use and disclosure of information about me as described in this Authorization & Release. I acknowledge receipt of a copy of this Authorization & Release.

_____ _____
Client Signature Date Parent/Guardian Signature Date