

Larry Cohen, LICSW

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AUTHORIZATION FOR RELEASE OF INFORMATION

TO: (Provider's name) _____

(Address) _____

(Phone) _____

I hereby authorize you and Larry Cohen, LICSW, to exchange with each other any and all information, both oral and written, concerning my history, condition and treatment for the purpose of coordinating and improving my treatment. I authorize that this information exchange may continue for one year commencing from the date of my signature, below. I understand that I may rescind this authorization at any time through a written statement signed by myself.

Client signature: _____ Date _____

Client name (printed) _____

Address _____
