Larry Cohen, LICSW • SOCIAL ANXIETY HELP
4808 43rd Place NW • Washington, DC 20016 • larrycohen@socialanxietyhelp.com • 202-244-0903

AUTHORIZATION FOR RELEASE OF INFORMATION

TO: Health care provider's name _____

Complete address _____

_____

Phone number _____

Email address _____

I hereby authorize you and Larry Cohen, LICSW, and any of his clinical associates at Social Anxiety Help, to exchange with each other my health information, both oral and written, for the purpose of coordinating and improving my treatment.

I place the following restrictions on the type of health information that I authorize you to exchange. [Please write "none," or specify the restrictions you place]:

Restrictions on information to be exchanged _____

_____

_____

_____

Unless otherwise restricted below, I authorize that this information exchange may continue indefinitely. I understand that I may rescind this authorization at any time through a written statement signed by. [Please write "none," or specify the end date for this authorization]:

End date for authorization _____

Client signature _____ Date _____

Client name (printed) _____ Date of birth _____

Address _____

_____