Authorization for the Release of Information To and From
Elizabeth Cohen, JD, LCSW

I, the undersigned, do hereby authorize Elizabeth Cohen, JD, LCSW to release information from the clinical record of

_____ _____ _____
name *birthdate* *social security*

to be given to _____
name and title of recipient

and accordingly release the same to communicate with Elizabeth Cohen, JD, LCSW orally and through written communication concerning treatment beginning

_____.
date

Information to be released (report may include information regarding drug, alcohol, and/or psychological treatment) is limited to

- ☐ *History*
- ☐ *Progress notes*
- ☐ *Consultation*
- ☐ *Other* _____

The reason* for this information is

- ☐ *Application for insurance claim*
- ☐ *Victim services compensation*
- ☐ *Worker's compensation*
- ☐ *Consultation*
- ☐ *Other*_____

In understand that I may revoke this consent at any time except to the extent any action has been taken.

_____ _____
client signature *date*