

# Joshua M. Cohen, Ph.D., LLC

Jackson Place  
966 Hungerford Dr., #32A  
Rockville, MD 20850

Office (301) 315-6301  
FAX (301) 315-6302

## AUTHORIZATION TO RELEASE INFORMATION

PATIENT: \_\_\_\_\_ DOB: \_\_\_\_\_

I authorize the following people to exchange information regarding my case.

JOSHUA M. COHEN, PH.D. 966 Hungerford Drive, #32A, Rockville, Maryland 20850.(301) 315-6301

AND

The following information may be shared:

- |   |  |
|---|--|
| <input type="checkbox"/> Medical Records            | <input type="checkbox"/> Neurological Evaluation       |
| <input type="checkbox"/> Education/Academic Records | <input type="checkbox"/> Behavioral Report             |
| <input type="checkbox"/> Psychiatric Evaluation     | <input type="checkbox"/> Teacher's Report              |
| <input type="checkbox"/> Psychological Evaluation   | <input type="checkbox"/> Treatment and/or              |
| <input type="checkbox"/> Verbal Exchange            | <input type="checkbox"/> Evaluation of Substance Abuse |
| <input type="checkbox"/> Other Exchange             |  |

I understand that I have the right to information about my treatment. I understand that my psychologist may require that I be present to interpret such information. I further understand that this information may not be re-disclosed without any authorization. This consent is valid for 12 months and is subject to revocation by me in writing at any time.

By submitting this AUTHORIZATION TO RELEASE INFORMATION, you agree that you have reviewed this information and agree to these conditions.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

If you use an Internet email service such as Yahoo or Hotmail, save the form and return it manually to [JoshuaMCohenPhD@Verizon.Net](mailto:JoshuaMCohenPhD@Verizon.Net) using your Internet email service.