CPHP Cohen Psychological Health Providers

966 Hungerford Drive
Suite 32A
Rockville, Maryland 20850

Authorization to Release Information

Patient Name ______________________________ Date of Birth ______________________________

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

Name	
Address	
Telephone Number	
Fax Number	
Email Address	

The following information may be shared:

- ☐ Medical Records
- ☐ Education/Academic Records
- ☐ Psychiatric Evaluations
- ☐ Psychological Evaluation
- ☐ Verbal Exchange
- ☐ Neurological Evaluation
- ☐ Behavioral Reports
- ☐ Teacher's Reports
- ☐ Substance Abuse Information
- ☐ Other Exchange

I understand that I have the right to control who receives information about my treatment and that I am not required to share information about my treatment. I further understand that information authorized for disclosure by this form may not be re-disclosed without further authorization. This consent is valid for 12 months and is subject to revocation by me, in writing, at any time.

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

______________________________ ______________________________

Signature of Patient/Guardian Date