# Cohen & Associates

Effective Solutions. Compassionate Care.

Rebecca S. Cohen, M.D.; Robin Bixler, DO; Teri Callender, LCSW, PA-C; K. Dawn Miner, Ph.D.

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## Authorization for Release/Exchange of Health Care Information

I, _____ DOB: _____

**hereby request and authorize the exchange of information about my care as I have initialed below between Rebecca Cohen, M.D., and/or Teri Callender, LCSW PA-C and/or Robin Bixler, D.O., and/or K. Dawn Miner, PhD**

Name of person to exchange information with: _____ at _____

Address: _____

City: _____ State: ____ Zip Code: _____

Phone Number: _____ FAX number: _____

**Information to be released or exchanged (initial all that apply):**

_____ Emergency room/urgent care records

_____ Hospital records including progress note and Admission/ Discharge Summaries

_____ Outpatient clinic medical records and progress notes

_____ Initial psychiatric evaluation records

_____ Psychiatric progress notes

_____ Psychotherapy progress notes

_____ Psychological test reports

_____ Laboratory reports and results

_____ Verbal consultation

_____ Emergency Contact

***Purpose of this consent:*** *by signing this form, you will consent to the use and disclosure of your protected health information to carry out treatment and healthcare operations. I understand that I may revoke this authorization at any time by making a written request. I understand that I have the right to refuse to sign this consent. This release shall be valid until the termination of treatment or until withdrawn in writing by the patient during treatment.*

**Patient Signature:** _____

**Date:** _____