Cohen & Associates
Effective Solutions. Compassionate Care.

Rebecca S. Cohen, M.D., Robin Bixler, DO, Teri Callender, LCSW, PA-C, Angelo Domingo, PsyD

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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 Angelo Domingo, PsyD

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

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 This release shall be valid until the termination of treatment or until withdrawn in writing by the patient during treatment.*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: _____