# Andrea Cohen, Psy. D.
## New York licensed Psychologist

# Authorization to Release Information

Client Name:_____

I hereby give Andrea Cohen, Psy. D., permission to obtain from, release information to, and/or discuss my case and my protected information with the company, agency, or individuals listed below:

_____

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_____

You have the right to revoke this authorization in writing at any time by sending such written notification to my email, andrea@reclaimedselftherapy.com. However, your revocation will jot be effective to the extent that I have already taken action in reliance on the authorization.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

Client Name (Print):_____

Client Signature: _____

Date: _____