JEFF COHEN, MFT

INTEGRATIVE MIND/BODY PSYCHOTHERAPY

1-510-548-4940 ▪ jeffcohenmft@gmail.com

RELEASE OF INFORMATION

I/We authorize Jeff Cohen to release to ______________________________
any pertinent information in my records for the purpose of treatment planning and coordination; or for other purposes as listed:

____

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Release of confidential information is subject to state and federal laws. By signing this release, I acknowledge my permission to release the specified information to the individual or agency I have named.

This authorization expires in one year unless otherwise stated.

______________________	______________________
(name)	(name)
______________________	______________________
(signature)	(signature)
______________________	______________________
(date)	(date)