Robert B. Cohen, Ph.D., P.A.

8813 Waltham Woods Road Suite 302
Baltimore, Maryland 21234
410 665-4522
www.worrydoc.net

10733 Birmingham Way Suite A
Woodstock, Maryland 21163
410 418-4318
Worrydoc@Comcast.net

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RELEASE OF INFORMATION

RE: _____

Date: _____

To: _____

I hereby authorize you to release to and to receive information from:

_____

Any information including the diagnosis and records of any treatment or examination to me during the period from_____ to _____

I understand this authorization shall remain valid from the date of my signature below and for 12 months thereafter or ending on: _____. I have been informed that I may revoke this authorization by written or oral communication to the Robert Cohen, Ph.D., P.A. I certify that this form has been fully explained to me and that I understand its contents.

_____
Signature

_____
Responsible Adult if minor

_____
Witness