***Susan Raab-Cohen, PhD, PS***

***2003 Western Ave., Suite 510***

***Seattle, WA 98121***

***(206) 443-9810***

**CONSENT FOR RELEASE OF PERSONAL HEALTH INFORMATION**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthday: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Give consent for Susan Raab-Cohen, PhD, to discuss personal information pertaining to my psychological services to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone if available:\_\_\_\_\_\_\_\_\_\_\_\_.

(Name of professional)

Release the following information:

\_\_\_\_\_\_ Health care information relating to the following treatment or condition:

\_\_\_\_\_\_ All health care information

This authorization expires in 90 days.

This authorization may be cancelled in writing as allowed by low. This would not affect any actions already taken based upon the original request. There are three ways to cancel this authorization:

1. Sign and date a recovation form; or
2. Write, sign and date a letter to cancel the authorization; or
3. Sign, date and write CANCEL on this original form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or legally authorized individual signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse (if requested) Date