Cognitive Care
SOLUTIONS
Comprehensive Cognitive Wellness

Release of Information
Authorization Form

I, _____hereby authorize Cognitive Care Solutions

and its affiliates and employees to release to _____

[Insert name of person/organization] my personal health information maintained by Cognitive Care Solutions (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided to me and which identifies my name, address, social security number, Member ID number) except the following information about me: _____

[Describe information not to be disclosed, if any] for the purpose of sharing my progress in therapy.

This authorization is valid from the date of my/my representative's signature below and shall expire upon the termination of treatment with Cognitive Care Solutions. I understand that I have a right to revoke this authorization by providing written notice to Allyson Lehrich, LCSW, President, Cognitive Care Solutions. I also understand that I have a right to a copy of this authorization.

Name of Client: _____

Signature of Client: _____

Date:_____

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Client identified above and will provide written proof if needed (e.g., Power of Attorney, etc.) that I am legally authorized to act on the Client's behalf with respect to this authorization form.

Name of Legal Representative: _____
Signature of Legal Representative: _____
Date: _____

Name of Witness: _____
Signature of Witness: _____