

**Marnie J. Cohen, LCSWR, RPT**

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**CONSENT FOR RELEASE OF INFORMATION**

DATE: \_\_\_\_\_,

I \_\_\_\_\_ do hereby authorize the release of any and all information regarding myself or my case to **Marnie J. Cohen, LCSWR, RPT**. In addition, I authorize Marnie J. Cohen, LCSW to communicate freely and without restrictions with:

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

This release is voluntary and it is my understanding it can be freely revoked at any time.

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

DATE: \_\_\_\_\_