

ERIKA MALM COOLEY, LCSW
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AUTHORIZATION FOR RELEASE OF INFORMATION

I, (FULL NAME) _____, HEREBY
AUTHORIZE ERIKA MALM COOLEY, LCSW (OR THE THERAPIST COVERING FOR
ERIKA COOLEY) TO EXCHANGE WITH ANY OF THE FOLLOWING INDIVIDUALS AND
ENTITIES, ANY CONFIDENTIAL INFORMATION CONTAINED IN ANY MENTAL
HEALTH, MEDICAL, OR SUBSTANCE ABUSE RECORDS WHICH THEY MAY HAVE
REGARDING ME (FULL NAME) _____.
THE PURPOSE OF SUCH DISCLOSURES IS TO FACILITATE ERIKA'S ABILITY TO
ASSESS AND TREAT ME AND TO PROVIDE CONTINUITY OF CARE. I MAY REVOKE
PART OR ALL OF THIS CONSENT AT ANY TIME.

SPOUSE/PARTNER: (FULL NAME AND PHONE)

PARENT(S): (FULL NAME AND PHONE)

PSYCHIATRIST: (FULL NAME AND PHONE)

PRIMARY DOCTOR/PEDIATRICIAN: (FULL NAME AND PHONE)

NUTRITIONIST: (FULL NAME AND PHONE)

OTHER SIGNIFICANT INDIVIDUALS IN MY LIFE: (FULL NAME AND PHONE)

SIGNED:

_____ DATE: _____