melissa mclain coffin, ph.d.
Licensed Psychologist
132 East Putnam Avenue ✷ Cos Cob, CT ✷ 06802
203-900-4904 ✷ drcoffin@mclaincoffin.com ✷ www.mclaincoffin.com

Consent for Release of Information

This form is required if you would like me to obtain or share information with another person about our work in therapy.

I, _____ hereby request and authorize
(Client or Guardian name)

Melissa Coffin, Ph.D. ❑ To Release to and/or ❑ To Obtain my health information from:

Name: _____ Title: _____

Phone: _____ Fax:_____ Email:_____

Address: _____

This authorization permits the above named entities and McLain Coffin Counseling, LLC. to disclose all of my health information that is in their possession, including information relating to any medical history, mental or physical condition and any received treatment, including without limitation: x-rays, other types of medical imaging, lab results, HIV/AIDS status, genetic testing, psychotherapy notes, any controlled substance information, any other mental health information, billing information, correspondence, and records held that originate from other entities not specifically named.

I understand that once McLain Coffin Counseling, LLC. discloses my health information, the above named entities could re-disclose my health information to third parties. I understand that I may revoke this authorization at any time by written notice except to the extent action has already been taken in reliance upon this authorization. This authorization is valid for a period of 1 year from the date of my signature unless otherwise specified.

Client/Guardian Signature: _____ Date: _____

Printed Name: _____

Relationship to client: _____ (self, guardian, parent)