



The Center for Treatment of Anxiety and Mood Disorders
Andrew Rosen Ph.D., FAACP

Statement of Release

Authorization to Request and/or Release Information

Client's Full Name: _____ Date of Birth: ____/____/____

I authorize Dr. Andrew Rosen to request and exchange confidential professional information, including personal, psychological, medical records and opinions, with:

Name of Person or Organization

Street Address

Phone

City

State

Zip Code

Name of Person or Organization

Street Address

Phone

City

State

Zip Code

Name of Person or Organization

Street Address

Phone

City

State

Zip Code

I understand that I have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time by informing Dr. Andrew Rosen or the above named parties. In consideration of this consent, I hereby release Dr. Andrew Rosen and the above named parties from any and all liability arising therefrom.

Signature of Patient or Legal Representative

Date

Print Name

Relationship to Patient

4600 Linton Blvd., Suite 310 | Delray Beach, FL 33445

www.drandrewrosen.com

Office: (561) 496-1094 | Fax: (561) 498-7698