AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name_____Date of Birth_____
SS #_____

Please Obtain Information From:

_____
Name of Provider

_____
Street Address

_____
City/State/Zip Code

Phone_____

Fax_____

Please Send Information To:

Gregory S. Cohn, M.D.

7301A W. Palmetto Park Road, Suite 202C

Boca Raton, Florida 33433

Phone (561)367-7447

Fax (561)367-7453

Description of Information to be released: (check all that apply)

_____Immunization record

_____Most recent history and physical

_____Laboratory reports

_____Consultations

_____Radiology/Imaging Reports

_____Progress Notes

_____EKG

_____Entire Medical Record

_____Other_____

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome, or Human Immunodeficiency Virus, behavioral or mental health, alcohol/drug(substance) abuse or any such related information.

Description of the purpose of the use and/or disclosure: (check all that apply)

_____Continuing Care

_____Second Opinion

_____Consultation

_____Other_____

X_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name Relationship