

JOSEPH T. COHN, M.D.
FAMILY PRACTICE
23 South First Avenue
Highland Park, NJ 08904
Office: 732-545-3434
Fax: 732-545-8915

*Starred items are required for completion of your request:

RELEASE MEDICAL RECORDS FROM:

RELEASE MEDICAL RECORDS TO:

Dr. Joseph T. Cohn _____

*Doctor/Medical Facility

*Name of Doctor/Company/Agency/Person

23 S. 1st Avenue _____

*Street Address

*Street Address

Highland Park, NJ 08904 _____

*City, State, Zip code

*City, State, Zip code

(732)545 - 3434 (732) 545 - 8915 _____

Phone Number

*Fax Number

() - () - _____

*Phone Number

*Fax Number

PATIENT INFORMATION:

*Print Patient's Full Name

*Date of Birth (Month/Day/Year)

*Street Address

*City, State, Zip Code

() - _____

*Phone Number

RELEASE THE FOLLOWING RECORDS:

_____ Last (2) years of medical records: () include/ () exclude _____

_____ Specific Records: _____

_____ Other: _____

*There is a fee for a personal copy of records

_____ I understand that information in my health record may include information relating to sexually transmitted disease, AIDS &/or HIV, and other communicable disease, behavioral health care, and the treatment of alcohol &/or drug misuse/abuse. My signature authorizes the release of this type of information.

_____ I may revoke this authorization at any time, except to the extent that any action based on this authorization that has already been taken.

_____ I understand that if this information is disclosed to a third party, the information may no longer be protected by state &/or federal regulations and may be re-disclosed by the person or organization that receives this information.

*Patient or legally authorized individual's signature

*Date

*Name of person signing this release

*Relationship to patient (eg. self/parent/guardian)