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:

Dr. Joseph T. Cohn
***Doctor/Medical Facility**

23 S. 1st Avenue
***Street Address**

Highland Park, NJ 08904
***City, State, Zip code**

(732)545 - 3434 (732) 545 - 8915
Phone Number *Fax Number

RELEASE MEDICAL RECORDS TO:

_____
***Name of Doctor/Company/Agency/Person**

_____
***Street Address**

_____
***City, State, Zip code**

( ) - ( ) -
***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)**