

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