David E. Cohen, M.D.
Cohen Vein Care
275 Forest Avenue – Suite 205
Paramus, New Jersey 07652
Tel: 201-265-5300
Fax: 201-265-5350

RELEASE OF CONFIDENTIAL INFORMATION

I, _____ am aware that David E. Cohen, M.D.LLC; Cohen Vein Care holds my medical information as confidential. My medical care and test results cannot be disclosed or discussed with anyone but myself without my permission. I understand this policy and by signing below I agree to allow David E. Cohen, M.D. LLC d/b/a Cohen Vein Care and staff to communicate with the people I have listed below. This permission will stand until changed by myself. I understand that it is my responsibility to forward any changes to this release in writing and verbal changes may not be honored.

David E. Cohen, M.D. LLC d/b/a Cohen Vein Care may leave information for me on my answering machine or voice mail.

Home YES_____ **NO**_____
Cell **YES**_____ **NO**_____
Work YES_____ **NO**_____
Fax **YES**_____ **NO**_____
Email **YES**_____ **NO**_____

My medical condition and bills may be discussed and shared with the following people:

_____

_____

_____

_____

_____

I understand this information will stay in my permanent medical record until I give written notice otherwise.

_____
PRINTED NAME OF PATIENT (OR REPRESENTATIVE)

_____ _____
SIGNATURE OF PATIENT (or Representative) DATE

_____
Relationship of Representative