MEDICAL RECORDS RELEASE

Date: _____

To: _____

_____

_____

Re: _____

(Print Patient's Name)

_____ _____

Date of Birth Social Security Number

_____

This authorizes you to release a copy of any and all medical records, diagnosis, treatment(s), and laboratory results to be sent to:

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

_____ _____

Patient Signature Date

Thank you for your immediate attention to this request