MATTHEW S. COHEN, MD, FAAP

272 West Park Avenue
Long Beach, NY 11561
Phone: (516) 543-5000
Fax: (516) 543-4180

Release of Records Authorization

TO: ____

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I hereby authorize you to release the complete history and medical records to:

MATTHEW S. COHEN, MD, FAAP
272 West Park Avenue
Long Beach, NY 11561
Telephone: (516) 543-5000
Fax: (516) 543-4180

PATIENT NAME: ______________________________ DOB: ____________

ADDRESS: ____

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____

SIGNATURE: ______________________________ DATE: ____________

WITNESS: ______________________________ DATE: ____________

PLEASE FORWARD ALL IMMUNIZATIONS, LAST PHYSICAL,
GROWTH CHARTS, AND ANY PERTINENT
MEDICAL INFORMATION