COHEN LASER AND VISION CENTER

3020 N. Military Trail, Suite #150 Boca Raton, FL 33431
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RECORDS RELEASE AUTHORIZATION

I, _____, authorize that my medical records be released

☐ To: ☐ From:

Office/Provider:_____

Address: _____

City:_____ State: _____ Zip:_____

Phone: _____ Fax: _____

For the period of _____ to _____

For the purpose of: ☐ continuing care ☐ insurance purposes ☐ other

(explain)_____

☐ To: ☐ From:

☐ Dr. G. Richard Cohen ☐ Dr. Joshua D. Cohen

Cohen Laser and Vision Center
3020 N. Military Trail – Suite 150
Boca Raton, FL 33431

Patient name: _____ DOB: _____

Patient ID # _____ Social Security # _____

Patient signature: _____ Date:_____

Witness signature: _____ Date:_____