



200 GARDEN CITY PLAZA SUITE 102  
GARDEN CITY, N.Y. 11530

(P) 516.246.5008  
(F) 516.740.0876

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

I, \_\_\_\_\_, hereby request and authorize  
(Name of Patient)

\_\_\_\_\_  
(Medical Practice)

to transfer my medical records, including all of my treatment records to:

VIA MAIL:

Benjamin R. Cohen, M.D.  
200 Garden City Plaza Suite 102  
Garden City, N.Y. 11530

VIA FAX:

Benjamin R. Cohen, M.D.  
Fax: (516) 740-0876

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

If patient is a minor, to be completed by parent or guardian.