NSPC
Brain & Spine Surgery

BENJAMIN R. COHEN, M.D., F.A.C.S.

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.