*Randi Cohen, MD, PhD*
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*(203) 450-3554 phone ● (888) 802-2584 fax*
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**Authorization to Release/Request Information To/From Primary Care Physician**

I, _____, date of birth: _____/_____/_____, hereby authorize Dr. Randi Cohen to obtain information from and share information with my primary care physician indicated below:

**Physician:** _____

**Address:** _____

_____

_____

_____ _____

**Signature of patient/parent/legal guardian** **date**

## RIGHT TO REFUSE COMMUNICATION BETWEEN PRIMARY CARE PHYSICIAN AND DR. RANDI COHEN:

I, _____, date of birth: _____/_____/_____, do not give my permission for Dr. Randi Cohen to communicate with my primary care physician.

_____ _____

**Signature of patient/parent/legal guardian** **date**