HEALTH DISCUSSION PERMISSION FORM

Patient Name_____

Patient DOB_____

I hereby grant permission for Dr. Michelle Cohen, OD to discuss the patient's relevant health history, diagnosis, and treatment with the following:

1. Agency/Individual Name_____

   Address_____

   Telephone_____ Fax_____

2. Agency/Individual Name_____

   Address_____

   Telephone_____ Fax_____

Signature_____ Date_____
Patient or Guardian/Agent

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