Joseph Cousin, M.D.

303 5th Avenue, Suite 1503
New York, NY 10016
(212) 518-3204

Authorization for Release of Information

Patient's name: _____

I hereby authorize Dr. Joseph Cousin, M.D. to contact and obtain and/or provide my medical history and other related clinical information from/to the following people:

Name:	Telephone:
_____	_____
_____	_____
_____	_____

I understand that this correspondence may involve a conversation or a transfer of written material and that I have the right to revoke the above authorization at any time.

Signature: _____ Date: _____

Printed Name: _____

Notice of Confidentiality

It is understood and agreed to by the recipient of the document or communications requested above that this is privileged information within the doctor-patient relationship, and is confidential material by law. Further disclosure or release of the documents or their contents by the recipient of any other party is not authorized without the above patient's written consent. Furthermore, it is understood that the patient may withdraw his/ her consent to this release at any time.