Gold Coast
Pediatrics
Aman Sekhon DO

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please release records to: GOLD COAST PEDIATRICS

Patient Name: _____ Date of Birth: _____

I authorize disclosure of the above named individual's protected health information as described below

THIS INFORMATION IS TO BE RELEASED FROM (PREVIOUS PHYSICIAN):

PHYSICIAN / FACILITY NAME: _____

_____ _____ _____ _____
ADDRESS CITY STATE: ZIP:

PHONE NUMBER: _____ FAX NUMBER: _____

INFORMATION TO BE RELEASED:

_____COMPLETE MEDICAL RECORD (All healthcare information including immunization record, well visits, labs, x-rays, growth charts, medication, allergies, specialist report, hospital notes, etc.)

_____OTHER (please specify): _____

RELEASE RECORDS TO:

GOLD COAST PEDIATRICS
18 Railroad Ave
Glen Head, NY 11545
Phone: 516-247-6005 Fax: 516-214-9686

_____ _____
Signature of Parent/Legal Guardian (required for under age 18) Date

_____ _____
Print Name of Parent/Legal Guardian Relationship to Patient