

Northport Pediatric & Adolescent Medicine  
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**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION  
 LEAVING PRACTICE**

<b>Patient Name(s) and          Date of Birth(s)</b>	<hr/> <hr/> <hr/> <hr/>	
<b>Patient(s) Address</b>		
<b>Patient(s) Phone          Number</b>		
<b>I hereby authorize the          release of all          necessary medical          records from:</b>	<b>Dr. Susan Gunduz, M.D., F.A.A.P.          Dr. Linda Moerck, D.O., F.A.A.P.          Northport Pediatric &amp; Adolescent Medicine          205 East Main Street, Suite 2-6,          Huntington, NY 11743          Tel: (631) 757-5604 Fax: (631) 266-2190</b>	
<b>New Physician/          Group Name</b>		
<b>Address</b>		
<b>Phone Number</b>		
<b>Fax Number</b>		
<b>Today's Date</b>		
<b>Patient/Parent          Signature</b>		