Gomathi Pediatrics PLLC
67 North Main Street, 2nd Floor
New City, New York 10956
Tel: 845-634-8911
Fax: 845-634-9002

Date:________________

PERMISSION REQUEST FOR 18 YEARS AND OLDER

____
Patient's Name

____
Patient's Date of Birth

By signing this form, I give Gomathi Pediatrics PLLC permission to speak to the following persons listed below in regards to my medical health and records.

Name: __________________________**Relationship:**_______________________

Name: __________________________**Relationship:**_______________________

Name: __________________________**Relationship:**_______________________

Name: __________________________**Relationship:**_______________________

Signature: _______________________________________

Date: ___________