

Great Destinations Pediatrics, P.C.
7757 W. Deer Valley Rd • Suite 275 • Peoria, AZ 85382
Telephone: (623)-878-2800 • Fax: 623-878-9150
www.gdpeds.com

Authorization to Release Immunization Record(s)

Patient Information:

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Address: _____

Phone: _____

I hereby authorize Great Destinations Pediatrics, PC to **SEND** photocopies of immunization records for above named patient(s) **TO:**

Practice/ Company or Person(s) authorized to receive records:

Name: _____

Address: _____

Phone: _____ **Fax:** _____

Email: _____

For the purpose of: _____

Records to be included:

_____ Immunization Record

In accordance with federal regulations, I hereby consent to the release of records pertaining to treatment/diagnosis of the following should records contain this information: Condition relating to drug and/or alcohol abuse, condition related to psychiatric/psychological treatment, AIDS/HIV, and communicable diseases.

This request will remain in effect for 1 year from the date of this request.

I understand that I may revoke this authorization at any time in writing except to the extent that action based on this authorization has already been taken.

Patient or legally authorized individual signature

Date

Printed name of signed on behalf of the patient

Relationship (parent, legal guardian, etc...)