Great Destinations Pediatrics, P.C.
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# 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:** _____

**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…)