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:** _____
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…)