Records Release Authorization

please print

Pediatrician/Office:

Name:_____
Address:_____
Phone:_____
Email: _____

I hereby authorize and request that you release
The immunization records and summary of treatment

During the period from: ____/____/_____ to ____/____/_____

To:

Pediatrics on Hudson
615 Broadway
Hastings-on-Hudson, NY 10706
914-963-1663
Email: forms@pediatricsonhudson.com (preferred)
Fax: 914-476-5373

For the following patient(s):

Patient name:_____DOB:____/____/_____

Patient name:_____DOB:____/____/_____

Patient name:_____DOB:____/____/_____

Patient name:_____DOB:____/____/_____

Home Address:_____
Phone:_____
Email:_____
Print Parent/Guardian Name:_____

Parent/Guardian signature:_____Date:____/____/____