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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name____________________________________ **Date of Birth**________________

❏ Request health information from:
❏ Request health information to:

Name of Person/Provider/Facility: ____

Address: ____

Phone:______________________________ Fax: ______________________________

This request and authorization applies to:

❏ All records regarding treatment of the patient.

❏ All records regarding treatment for the following condition: ____________________________

❏ Immunization records only

❏ Other: ____

This authorization expires: On this date_____/_____/_____ or one year from the date signed.

Authorization:

Signature____ Date ________________

Print Name____ Phone ________________

Relationship: ❏ Parent ❏ Guardian ❏ Patient

To Patients:
Please allow 24-48 hours for the release of immunization records and 2 weeks for the release of all other healthcare information, unless an earlier date is requested and approved.