Willoughby Beach Pediatrics

help@willoughbybeachpediactrics.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (VACCINES ONLY)

I, _____ (PARENT/GUARDIAN NAME) do hereby authorize WILLOUGHBY BEACH PEDIATRICS to release medical information pertaining to the patient listed below.

Patient Name: _____ Patient Date of birth: _____

Street Address: _____ **City,**

State, Zip: _____ **Best Contact**

Number: _____

[ ] I DO [ ] I DO NOT Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (human Immunodeficiency
Virus Infection), psychiatric care and or psychological assessment and treatment and treatment for alcohol and or drug abuse.

Please release the following
X_ immunization record

Release information to
Name (Physician, Hospital, Agency, etc.) _____

Street Address: _____ City State

Zip:_____Phone: _____Fax:_____

Email:_____

I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification and it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re disclosure by the person or class of persons or facility receiving it and would no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

Required Signature: ____ Date: ______________