Golden Gate Pediatrics - *A Medical Corporation*

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Authorization for Disclosure of Patient Immunization Record

Please provide all information requested or this Authorization is not valid. Please Print.

Patient Name: ______________________________ Date of Birth: ____________________

Address: ____

Telephone Number: (______)__________________________

I hereby authorize ____
(Facility/Provider Name and Location)

For the following purpose:

- ☐ Transferring to adult MD
- ☐ School
- ☐ Camp
- ☐ Patient Request
- ☐ Moving
- ☐ Other (please specify) ______________________

____

This information may be disclosed to and used by the following individual or organization:

Name: ____

Address : ____

Telephone Number: (______) ________________________ Fax Number: (______)________________________

This authorization will be valid for 180 days from the date it is signed or until ______________, whichever is shorter.
This authorization may be revoked at any time by notifying the above named provider of information in writing, except when this authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Information used and disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

____
Signature of Patient or Legal Guardian
(Parent/Legal Guardian must sign if patient is a minor)

____
Relationship to Patient, if not the patient

Date: ____________________________________

Office Use Only
Copied by:________ Date:_________
To be sent ☐
To be picked up ☐ Date:___________

Sent on date: ____________________