Records Release Authorization

Pediatrician/Office Name:____

Office Address:____

____

I hereby authorize and request that you release

The Immunization Records and Summary of Treatment

During the period from ____/____/________ to ____/____/________
MM DD YYYY MM DD YYYY

To:

Pediatrics on Hudson
615 Broadway
Hastings on Hudson, NY 10706
Fax: (914) 476 – 5373

For the following patient(s):

Patient Name:____________________________________DOB:____/____/________

Patient Name:____________________________________DOB:____/____/________

Patient Name:____________________________________DOB:____/____/________

Patient Name:____________________________________DOB:____/____/________

Home Address:____

City:______________________________State:________Zip:___________________

Print Parent/Guardian Name:____

Parent/Guardian Signature:______________________________Date:____/____/____