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: 914-415-4918

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:____/____/____