ESTRELLA PEDIATRICS, P.C.

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Phoenix, AZ 85037

Telephone (623) 388-3216 Fax (623) 388-4902 Medical Records fax (623) 225-7967

AUTHORIZATION TO RELEASE IMMUNIZATION RECORD

Patient Name: _____ Date of Birth: _____

PRINT PATIENT LAST NAME, FIRST NAME

Address: _____

_____

Phone #: _____ Cell #: _____ Responsible Party S.S. #:_____

I hereby authorize Estrella Pediatrics, P.C. to send/release photocopies of immunization records concerning the above named patient to:

_____

Name of Practice/Company/Person(s) Authorized to receive Immunization Record only

_____

Address Fax Number

I authorize the release of the Immunization Record only. I understand that when my child's information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I am aware that it is important for me, as the parent/legal guardian, to maintain the original immunization record booklet for my child, and to bring the booklet for each well check visit. This authorization shall be considered invalid after 60 days.

I understand and agree that I may be responsible for the following fees associated with my request: copying charge (supply cost, labor, and postage, or fax fee) related to the reproduction of my child's information. One copy per year is deemed reasonable and will be provided (upon request) as a courtesy. Any additional requests will have a minimum charge of $5.00.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Print Name of Parent/Legal Guardian Relationship to Patient

Signature Verified ( ) Yes ( ) No Estrella Pediatrics, P.C. Employee Initials: _____