ALPINE PEDIATRICS

Authorization to Release Immunization Records to Schools

I authorize Alpine Pediatrics P.C., to release the immunization records of my child(ren) listed below to schools that may request them:

Patient Name:		Date of Birth / /	
Address	City	State	Zip
Phone Number ( ) -	Relationship to Patient		
Patient Name:		Date of Birth / /	
Address ☐ Same as Previous	City	State	Zip
Phone Number ( ) -	Relationship to Patient		
Patient Name:		Date of Birth / /	
Address ☐ Same as Previous	City	State	Zip
Phone Number ( ) -	Relationship to Patient		
Patient Name:		Date of Birth / /	
Address ☐ Same as Previous	City	State	Zip
Phone Number ( ) -	Relationship to Patient		
Patient Name:		Date of Birth / /	
Address ☐ Same as Previous	City	State	Zip
Phone Number ( ) -	Relationship to Patient		
Patient Name:		Date of Birth / /	
Address ☐ Same as Previous	City	State	Zip
Phone Number ( ) -	Relationship to Patient		
Patient Name:		Date of Birth / /	
Address ☐ Same as Previous	City	State	Zip
Phone Number ( ) -	Relationship to Patient		
Patient Name:		Date of Birth / /	
Address ☐ Same as Previous	City	State	Zip
Phone Number ( ) -	Relationship to Patient		

Once Alpine Pediatrics, P.C., discloses my health information by my request, it cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to adhere to this authorization or state and federal laws pertaining to the use and disclosure of my health information

This request will remain in effect until revoked in writing or until patient graduates from High School. Alpine Pediatrics, P.C. may not be able to stop the use of your health information during the period the authorization was in effect.

Signature of Biological Parent or Legal Representative:		Date / /
Printed Name	Relationship to Patient	