

Golden Gate Pediatrics,

A Medical Corporation

San Francisco Office - 3641 California Street, San Francisco, CA 94118 (415)668-0888 (415)752-5391 - fax
Mill Valley office - 61 Camino Alto, #107, Mill Valley, CA 94941 (415)388-6303 (415)388-7136 - fax

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: _____