



glenbrookpediatrics

**Authorization for the Release of Vaccination/Immunization Records**

I, \_\_\_\_\_ hereby authorize

Parent/Guardian , Please Print

Glenbrook Pediatrics, S.C. to release the immunization records for my  
minor child \_\_\_\_\_ . I request the records be:

Child's Name

\_\_\_\_\_ Available for me to pick-up in person

\_\_\_\_\_ Mailed to me at \_\_\_\_\_

Faxed to:

\_\_\_\_\_ Myself at: \_\_\_\_\_

\_\_\_\_\_ To Doctor: \_\_\_\_\_ at: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

.....  
**OR , If Over 18 Years Old**  
.....

I, \_\_\_\_\_ hereby authorize

Patient Name, If over 18 years of age

Glenbrook Pediatrics, S.C. to release the immunization records for  
myself. I request the records be:

\_\_\_\_\_ Available for me to pick-up in person

\_\_\_\_\_ Mailed to me at \_\_\_\_\_

Faxed to:

\_\_\_\_\_ Myself at: \_\_\_\_\_

\_\_\_\_\_ To Doctor: \_\_\_\_\_ at: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_