Allegro PEDIATRICS
2475 140th Ave. NE
Bellevue, WA 98005
Fax: (425) 460-3374
RecordsRelease@allegropediatrics.com

AUTHORIZATION TO RELEASE IMMUNIZATION RECORDS & FORMS BY UNSECURE EMAIL

Patient Name _____ Date of Birth ___/___/_____

Contact Numbers ( )_____ ( )_____

I authorize the following organization to release information as stated below from the patient health information record:

INFORMATION TO BE RELEASED TO:	
Organization / Person	Phone
Street Address	City, State, Zip
Email Address	Confirm Email Address

INFORMATION TO BE RELEASED:	
☐ Immunization Records	☐ Forms (please specify): _____

AUTHORIZATION FOR GENERAL RELEASE INFORMATION

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by written notification to Allegro Pediatrics. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further releases or distribution by the recipient that may not be protected by confidentiality laws.
- I acknowledge that e-mail is not a secure method of communication and the health information may be intercepted while in transit. I understand this risk and consent to Allegro Pediatrics sending the information via unsecured and unencrypted e-mail to the above e-mail address at my request.

This authorization will expire 1 year from the date signed below unless another date or event is entered here _____

SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE

_____ _____

Patient Name Date

_____ _____

Signature of patient or parent/guardian if patient is under 18 Parent/Guardian Name & Relationship to Patient

By typing your name in the signature field, you confirm that the information provided above is accurate to the best of your knowledge and authorize disclosure of the requested information.