

HELENA PEDIATRIC CLINIC, P.C.  
1122 N. MONTANA AVE.  
HELENA, MT 59601  
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ERIN GREEN, D.O.  
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**RECORDS REQUEST IMMUNIZATIONS ONLY**

DATE: \_\_\_\_\_

CHILD'S LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ DOB \_\_\_\_\_

PARENT'S LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

**I AUTHORIZE THE FOLLOWING FACILITY TO RELEASE:**

HELENA PEDIATRIC CLINIC, P.C.  
1122 N MONTANA AVE  
HELENA, MT 59601

**PLEASE SEND THE INFORMATION TO:**

CLINIC/SCHOOL/DAYCARE/PERSON \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**DELIVERY METHOD: PICK UP** \_\_\_ **MAIL** \_\_\_ **FAX** \_\_\_ **FAX#** \_\_\_\_\_

I UNDERSTAND THAT THIS AUTHORIZATION MAYBE REVOKED BY ME AT ANYTIME, PROVIDED THAT I DO SO IN WRITING PRIOR TO THIS RELEASE HAVING ALREADY BEEN DONE. I ALSO UNDERSTAND THAT MY PROTECTED HEALTH INFORMATION MAYBE DISCLOSED BY THE RECIPIENT AND IS NO LONGER PROTECTED UNDER FEDERAL LAW. THIS AUTHORIZATION WILL EXPIRE IN 12 MONTHS, UNLESS STATED OTHERWISE.

PATIENT SIGNATURE (IF OVER 18) \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/LEGAL GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

RELATIONSHIP TO CHILD \_\_\_\_\_

Office use only: Records sent by \_\_\_\_\_ Sent Date: \_\_\_\_\_