Authorization to Release Immunization Records

Date: _____

To Whom It May Concern,

I, **[Your Full Name]**, born on **[Your Date of Birth]**, hereby authorize **[Name of Facility/Provider]** to release my immunization records to:

[Recipient's Name]
[Recipient's Address] [City, State, Zip Code]
[Recipient's Email/Phone Number]

This authorization is valid until **[Specify Date or "indefinitely"]**.

I understand that I have the right to revoke this authorization at any time by providing written notice to the facility or provider listed above.

Thank you for your assistance.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email]