REQUESTS FOR COPIES OF THE IMMUNIZATION RECORDS FOR

Name: _____ Date of Birth: _____

Other names records may be under_____

I authorize the release of records

FROM:
Tolt River Family Medicine
PO Box 1184
Carnation, WA 98014
Phone 425-333-4600
Fax 425-333-4646
ToltFamily.com

TO: Parent / Guardian / Patient / School District
(Circle one)

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Information to be released:

- ❑ Immunization Records
- ❑ Proof of Immunity Blood Tests

Your records will be mailed within 7 business days of receiving this request. This authorization expires 90 days after the date it is signed. There is a $10 handling fee for sending copies of immunization records. Payment must accompany this request. Please make check payable to Tolt River Family Medicine.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name:_____

Office Use Only

Payment received: _____

Mailed on: _____

Initials_____