

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.

We provide families with a Lifetime Immunization Booklet and encourage families to keep it up to date as you will need access to it regularly for school/camp registrations or travel. Each time your child receives a vaccine make sure you write it in the booklet so that you have a complete record and can avoid having to pay for records request fees.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

Office Use Only
Payment received: _____
Mailed on: _____
Initials _____