

ELYRIA CITY HEALTH DISTRICT IMMUNIZATION
RECORD REQUEST

Today's Date: _____

Name of Child: _____

(Please Print)

Child Birthdate: _____

Your Name: _____

Your Relationship to Child: _____

Phone Number: _____

**WE WILL MAKE EVERY EFFORT TO COMPLETE YOUR RECORD REQUEST
WITHIN (3) WORKING DAYS.**

Please select ONE option below indicating how you would like to be notified of completed request. PLEASE PLACE YOUR INITIALS ON THE LINE IN FRONT OF YOUR SELECTION TO INDICATE YOUR CHOICE.

_____ Please notify me by telephone at the following number(s) that the record is available to be picked up:

_____ Please **FAX** record to the following agency (include agency fax number):

Agency: _____

Fax No: _____

_____ Please **MAIL** record to the following address (include school / agency name):

Agency: _____

Address: _____

City/Zip: _____

I give authorization for this record to be released by telephone, fax, or mail, as indicated above, to the agency/agencies listed above.

Parent Signature: _____ **Date:** _____

I have received and/or read, and understand your Notice of Privacy Practices regarding the uses and disclosures of my/my child's health information.

Parent Signature: _____ **Date:** _____

THANK YOU

