ELYRIA CITY HEALTH DISTRICT
IMMUNIZATION RECORD REQUEST

(Please print)

Today's Date:________________________________

I would like to obtain the following immunization record(s):

Name of Client:	**Client Birthdate:**	**Your Relationship to Client:**
______________________________	______________________	______________
______________________________	______________________	______________

Your Name:____

Your Telephone Number:____

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

Please select ONE option below indicating where you would like this immunization record to be forwarded. PLEASE PLACE YOUR INITIALS ON THE LINE IN FRONT OF YOUR SELECTION TO INDICATE YOUR CHOICE. Then mail, fax or bring completed form to:

Elyria City Health District
202 Chestnut Street
Elyria, OH 44035
(440) 323-7595 (Phone)
(440) 284-1558 (FAX)

______ 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(s) (**include agency fax number**):

Agency:______________________________ Fax No: ____________________
Agency:______________________________ Fax No: ____________________

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

Agency:____
Address:____
City/Zip:____

I give authorization for the information in this immunization record to be released by telephone, fax, or mail, as indicated above, to the person /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/child's health information.

PARENT SIGNATURE: __________________________________ **Date:** ____________

F:\pedimmrequestWEB.doc
Revised 07/08/10

Imm. record request completed on: ________________
Completed by (initials): ________________