



3650 JOSEPH SIEWICK DRIVE, SUITE 101 FAIRFAX, VA 22033 703.391.0900 fax: 703.391-2919

## IMMUNIZATION RELEASE REQUEST

Transferring Out of FPA? Y or N

Please release one copy of my child(ren)'s immunization record to :

\_\_\_\_\_ name of facility/school and or person

\_\_\_\_\_ address

\_\_\_\_\_ city/state/zip

\_\_\_\_\_ phone number

\_\_\_\_\_ fax number

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

This request is limited to one time only.

This information may, in certain instances, be re-disclosed by the recipient of the information, in which case it is no longer subject to the HIPAA privacy standards.

Thank you.

\_\_\_\_\_  
Signature of Individual or Legal Guardian

\_\_\_\_\_  
Date

7/26/10