13135 Lee Jackson Memorial Hwy, Suite 201 Fairfax, VA 22033 Ph: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

3/17/13