IMMUNIZATION RECORD REQUEST

TODAY’S DATE: ______________

PLEASE INDICATE NUMBER OF COPIES/ORIGINALS: **COPY $3.00**  **ORIGINAL $5.00**

Required Information (so we can contact you when your records are ready):

YOUR NAME: _______________________________________________________________

PHONE: Home: ___________ Cell: ___________ Work: ______________

FAX #: ___________________ e-mail address: ___________________________

MAIL ADDRESS: _________________________________________________________

____________________________________

Complete the following information for each patient record requested:

Patient’s Name: Last: ___________________ First: _____________________

Date of Birth: Month _________ Day ____________ Year _____________

Patient’s Name: Last: ___________________ First: _____________________

Date of Birth: Month _________ Day ____________ Year _____________

Patient’s Name: Last: ___________________ First: _____________________

Date of Birth: Month _________ Day ____________ Year _____________

Completed forms can be returned to El Paso County Public Health, faxed (with cover) to the number above or mailed to 1675 W. Garden of the Gods Rd., Suite 2044, Colorado Springs, CO 80907. Please allow up to 7 business days for us to mail, fax or prepare your records for pick-up at Public Health’s Immunization Clinic.

FOR PUBLIC HEALTH USE ONLY: Date Completed ____________  PA Initials _________