HOLMES COUNTY HEALTH DISTRICT

85 North Grant Street · Millersburg, Ohio 44654 · (330) 674-5035 · Fax (330) 674-2528
Website www.holmeshealth.org

HEALTH COMMISSIONER:
MIchael Derr, MBA

MEDICAL DIRECTOR:
Mark Stutzman DO

HOLMES COUNTY HEALTH DISTRICT

IMMUNIZATION RECORD REQUEST

Today's Date: _____

I would like to obtain the following immunization record(s):
NOTE: Permission must be signed by client (if age 18 or over) OR by parent of underage client.

Full Name of Client:	Client Birthdate:	Your Relationship to Client:
_____	_____	_____
_____	_____	_____

Person Making Request: Your Telephone #:

WE WILL MAKE EVERY EFFORT TO COMPLETE YOUR RECORD REQUEST WITHIN 3-5 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, email or bring completed form to:

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info@holmeshealth.org

☐ 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 person/ agency(s) (include fax number):
Person/Agency: Fax No:
Person/Agency: Fax No:

☐ Please MAIL record to the following address (include person/ school/ agency name):
MailTo:
Address: City: ST: 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(s) listed above.

CLIENT OR 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.

CLIENT OR PARENT SIGNATURE: _____ Date: ___ ___ ___ ___

Request completion date:

Completed by (initials):