

Town & Country Pediatrics

Medical Records Department

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Vaccination Record Request Form

### Vaccination Record Request Form

Your child's school, camp or daycare may require that you provide a current vaccination record of your child.

Lurie Children's Primary Care-Town & Country Pediatrics can provide an updated vaccination record at no charge.

Please allow Town & Country Pediatrics two business days to complete your request.

Please complete the information below, sign and date where indicated. Your signature represents that you are the legal parent or guardian of the minor child who is Town & Country Pediatrics patient. You therefore act as the minor child's personal representative as HIPAA defines that term. That means that you may have access to the minor child's Protected Health Information. You agree to notify Town & Country Pediatrics if your status as the minor child's personal representative changes for any reason. In unusual circumstances HIPAA may prohibit Town & Country Pediatrics from continuing to provide you with such access to the minor child's Protected Health Information. If those unusual circumstances ever arise, then Town & Country Pediatrics will explain why.

Please provide the following information:

PATIENT INFORMATION	TODAY'S DATE:
Last Name:	First Name:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB:

PARENT/GUARDIAN		
Last Name:	First Name:	
Address:		
City:	State:	Zip:
Home Telephone #:	Cell Phone #:	

DELIVERY METHOD
<input type="checkbox"/> MyChart
<input type="checkbox"/> Mail (Enter USPS Mailing Address):
<input type="checkbox"/> Pick Up (Select location) <input type="checkbox"/> Halsted Location <input type="checkbox"/> Skokie Location <input type="checkbox"/> Glenview Location

**Information will be used for the following purpose:**

<input type="checkbox"/> <b>Not Transferring Out of Practice (please specify):</b>	<input type="checkbox"/> <b>Transferring Out of Practice (please specify):</b>
<input type="checkbox"/> My personal use	<input type="checkbox"/> Moving <input type="checkbox"/> Aged-Out
<input type="checkbox"/> Sharing with other health care providers	<input type="checkbox"/> Insurance <input type="checkbox"/> Dissatisfied
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Sharing with other health care providers

NAME OF PERSONAL REPRESENTATIVE: \_\_\_\_\_

SIGNATURE OF PERSONAL REPRESENTATIVE: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_