Lurie Children's Primary Care
Town & Country Pediatrics
Medical Records Department
Phone: (312) 227-2806
Fax: (312) 227-9554
Email: TCPrecords@luriechildrens.org
Vaccination Record Request Form

3324P

Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

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: ☐ Male ☐ Female	DOB:

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

DELIVERY METHOD			
☐ **Pick Up** *(Select location below)*	☐ **Mail** *(Enter Mailing Address below)*	☐ **Email *** *(Enter Email Address below)*	
Pick Up Location:	☐ Halsted Location	☐ Skokie Location	☐ Glenview Location
Mailing Address:			
Email Address:			

Information will be used for the following purpose:

☐ ***Not Transferring Out of Practice (please specify):***	☐ ***Transferring Out of Practice (please specify):***
☐ My personal use	☐ Moving ☐ Aged-Out
☐ Sharing with other health care providers	☐ Insurance ☐ Dissatisfied
	☐ Sharing with other health care providers
☐ Other *(please specify)*	

NAME OF PERSONAL REPRESENTATIVE: _____

SIGNATURE OF PERSONAL REPRESENTATIVE: _____

RELATIONSHIP: _____ **DATE:** _____ **TIME:** _____

*****By checking this box, I agree to receive email communication that may contain protected health information. I understand that email transmissions cannot be guaranteed to be delivered, secured or error-free despite best efforts of sender. Sender does not accept liability for errors resulting from transmission.