CHILDREN'S HEALTHCARE ASSOCIATES, LLP
RELEASE OF IMMUNIZATION RECORD

You must be a parent or legal guardian for the child whose record you are requesting or of legal age for your own record. Please fill out the information below, sign, date, and return to clinic staff.

1. Name: _____
Last First Middle

Date of birth: _____

2. Name: _____
Last First Middle

Date of birth: _____

3. Name: _____
Last First Middle

Date of birth: _____

4. Name: _____
Last First Middle

Date of birth: _____

5. Name: _____
Last First Middle

Date of birth: _____

I, _____ hereby give permission to CHILDREN'S HEALTHCARE ASSOCIATES, LLP., as the Parent or Legal Guardian to release a copy of the immunization records for all persons named.

_____ _____ _____
Signature Phone Number Date

_____
Relationship

***Please note not all immunization providers in Texas submit information to ImmTrac the Statewide Immunization Information System. There is a chance your child's complete record may not be found in CHA's clinic records or ImmTrac, the record may have incomplete information.**

08/12: