Soundview Medical Associates, LLC

Patient Proof of Immunization Record Request

Patient name ___________________________________ DOB: _________________________
(print)

Medical Record #__________________________

I ____ hereby request the following:
(Patient* and/or Patient Representative**)

- To receive a copy of my immunization record
- For Soundview Medical Associates, LLC to disclose my or my child's immunization records to: ______________________________________ as required by State or other
  (school name)

  law for school admittance.

**Patient must be 18 years of age or documented emancipated minor.*

***Patient representative may be a parent, guardian, or other person acting in loco parentis of the individual. Immunization records may only be disclosed to a school as required by State or other law.*

Request must be submitted in writing to Soundview Medical Associates, LLC at 761 Main Avenue, Norwalk, CT 06851. If approved, an agreed upon date, time and place will be scheduled for pick up, or a copy will be mailed by return receipt to the designated school at the address indicated below. A nominal fee may be charged for the paper or electronic copy of the immunization record. If the request is denied, the patient and/or patient representative will be informed as to the reason why.

Date: _____________________________________

Time: _____________________________________

Place: ____

OR

School Name: ____

School Address: ____

Received copy of Records: ____
(Signature of Patient* and/or Patient Representative*) (if records hand delivered)

Date: _______________________________

<u>OFFICE USE ONLY</u>

Request received by: __________________________________ Date: _____________________