Seneca County General Health District

Medical Record Request (Immunization-TB)

☐ **Immunization record** ☐ **Tuberculosis Skin Test—Mantoux**

*** All requests will require Photo Id (Drivers License, State Identification card or Passport) ***

Date of Request: _____ Number of copies requested **($10.00 each)** ☐ 1 ☐ 2 or _____

Patient Information: Print Name: _____

Date of Birth: _____ /_____ /_____ Phone #: _____

Current Address: _____

Any alternate name(s) that may be on the requested record: _____

Person Requesting Information (*if patient is a minor, person requesting a record must be a legal guardian):

Name (First, Last): _____ Relation to Patient*: _____

Phone Number: _____ Reason for Request: _____

I authorize Seneca County General Health District (SCGHD) to release my record(s) to the individual or entity listed below:

Name: _____ Relationship to Patient: _____

Address: _____

Delivery Options: (Records will be mailed to the address under Patient Information)

Fax #/Email Address*: _____ Attention to: _____

** If you select the fax/e-mail option, you hereby acknowledge and accept the inherent risk associated with an unsecured transmission, which can place your information at risk of being read or accessed by someone else, and you agree that Seneca County General Health District will not be responsible for disclosures that might occur in transit. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.*

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

HEALTH DEPARTMENT STAFF USE ONLY

Amount paid: _____ ☐ cash ☐ check ☐ Credit Card Receipt number: _____

Completed Date: _____ Requested Completed by: _____

Delivery: Mail / Fax / Email / Office Verified ID ____ Verified guardian status _____