



Immunization Record Request

Date of Request: _____

Patient Information:
Name (First, Last): _____ **Patient Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Person Requesting Information (*if patient is a minor, person requesting a record must be a legal guardian):
Name (First, Last) _____ **Relation to Patient*:** _____

Method of Delivery: ☐ **Pick-up** ☐ **Mail** ☐ **Fax*** ☐ **E-mail***

** If you select the e-mail/fax 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 Wyandot County Public Health 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.

I authorize Wyandot County Public Health (WCPH) to release my immunization record to the individual or entity listed below:

Mail
Name: _____

Address: _____ **City:** _____ **State:** _____

Zip Code: _____

Fax
Fax #: _____ **Attention to:** _____

Email
Email: _____ **Attention to:** _____

Office Use Only-(Revised 07/15/2025)

Request completed by: _____ **Title:** _____ **Date of completion:** _____