

[Date]

[Previous Doctor's Name or Clinic Name]

[Clinic Address]

[City, State, Zip Code]

[Phone Number]

[Fax Number]

RE: Request for Pediatric Immunization Records

Patient Name: [Child's Full Name]

Date of Birth: [MM/DD/YYYY]

To Whom It May Concern,

I am writing to request a copy of the complete immunization records for the patient listed above. My child is transferring to a new pediatric provider, and we require these records for their upcoming appointment and school enrollment.

Please send the records via the following method:

- Fax to: [New Clinic Fax Number]
- Email to: [Parent Email or New Clinic Email]
- Mail to: [New Clinic Name/Address or Home Address]

I have attached a signed release of information form if required by your office. Please process this request as soon as possible.

Thank you for your assistance.

Sincerely,

[Parent/Guardian Signature]

[Parent/Guardian Printed Name]

[Phone Number]