Date: [Current Date]

To: [Previous Clinic/Provider Name]
Address: [Clinic Address]
Phone: [Clinic Phone Number]
Fax: [Clinic Fax Number]

RE: Request for Pediatric Immunization Records

Patient Name: [Child's Full Name]
Date of Birth: [Child's Date of Birth]

To Whom It May Concern,

I am writing to formally request a complete copy of the immunization records for the child listed above. This information is needed for [Reason: school enrollment / transfer to a new physician / personal records].

Please send the records via the following method:

- Fax to: [New Provider Fax Number]
- Email to: [Email Address]
- Mail to: [Mailing Address]

I have attached a signed medical release form authorizing the transfer of these records. If there are any fees associated with this request or if further information is required, please contact me at [Your Phone Number].

Thank you for your prompt assistance with this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
Relationship to Patient: [Parent / Legal Guardian]