WALLA WALLA COUNTY
HEALTH DEPARTMENT
314 W Main Street • PO Box 1753
Walla Walla, WA 99362
Phone 509.524.2650 • Fax 509.524.2678
vitalrecords@co.walla-walla.wa.us

INDIVIDUAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

DATE: _____

I hereby authorize Walla Walla County Health Department, P.O. Box 1753, Walla Walla, WA 99362 to furnish the following information concerning my care/my child's care to:

REQUESTOR'S NAME: _____

REQUESTOR'S ADDRESS: _____

REQUESTOR'S CITY: _____**STATE**_____**ZIP**_____

REQUESTOR'S TELEPHONE NUMBER: _____

DATA REQUIRED: _____**IMMUNIZATION HISTORY**

Circle one: I would like this Immunization Record sent to me by:

☐ **Mail** ☐ **Confidential Fax** ☐ **Email**

I understand that Email is subject to Public Records Search.

FAX NUMBER OR EMAIL ADDRESS: _____

Immunization Record is requested for the following:

CLIENTS NAME: _____

CLIENTS ADDRESS: _____

CLIENTS CITY: _____**STATE**_____**ZIP**_____

CLIENTS TELEPHONE NUMBER: _____

OTHER NAMES USED: _____

BIRTHDATE: _____/_____/_____ **SEX:** _____ **RACE:** _____

DATE INFORMATION NEEDED: _____/_____/ _____

PLEASE SELECT ONE: SELF PARENT OTHER:SPECIFY _____

SIGNATURE: _____**DATE:** _____/_____/ _____

Office Use Only

INFORMATION USED TO VERIFY IDENTITY:

DATE INFORMATION FURNISHED: _____/_____/_____**BY:** _____