



RECORDS REQUEST FORM

PATIENT NAME

PATIENT DOB

PARENT/GUARDIAN NAME

I, _____ authorize **Benton-Franklin Health District** to release the following records according to the instructions listed below.

- Immunizations (fee applies)
- PPD (TB test results)
- Other (specify) _____

- I understand that these records are protected under federal and state confidentiality regulations and cannot be disclosed without my written consent unless provided for in the regulations. I also understand that I may revoke this authorization in writing at any time.
- A copy may be considered the same as an original.

Duplicate Immunization Records Fee

Benton Franklin Health District provides each client with a record of immunizations at the time of service. It is the responsibility of each client to maintain their own records. Requests for additional copies of the immunization records will be charged a \$5.00 duplicate record search fee. These fees must be paid prior to receipt of the immunization records. If no record is found, the fee will be returned to you. Methods of payment accepted are cash, check and credit/debit card.

Select One

This consent will automatically expire 90 days from date of signature below (per RCW 70.02.030) unless otherwise indicated here. _____ (mm/dd/yyyy)

Select One

I will pick up a copy of my records at the: (allow 24 hours)

- Benton-Franklin Health District (Kennewick office – 7102 W. Okanogan Place)
- Benton-Franklin Health District (Pasco office – 412 W. Clark St.)
- Benton-Franklin Health District (Prosser Office- 310 7th St.)

Please fax to: _____

Please mail to: _____
Attn: _____

Patient or Parent/Guardian Signature

Date

For Office Use Only

SEARCH PERFORMED Records Found ____Y ____N

Magic # _____ Child Profile Historical Card File Medical Chart Other _____

Records request completed by: _____ Date: _____

Employee Signature