

Immunization Records Request Form

HEALTH RECORD RETENTION POLICY: All students are encouraged to establish a personal file for their medical records. Immunization documents are retained by the college for five (5) years only and then destroyed.

Requests will be processed within 10 business days.

Last Name: _____ First Name: _____ Student ID #: _____
Other/Maiden Name(s) : _____ Date of Birth: (mm/dd/yyyy) _____
SSN: _____ Phone: _____ Dates of Attendance: _____
Address: _____ City: _____ State: _____ Zip: _____

Check all that apply :

- I will pick up a copy of my immunization records. Please call me when they are ready at the number listed above.
- Please mail a copy of my immunization records to my address listed above.
- Please fax a copy of my immunization records to:

Name _____ and Number: _____

- Please forward a copy of my immunization records to:

Student Signature: _____ Date: _____

FOR OFFICE USE ONLY:

RCVD: _____ INITIALS: _____

This fax/e-mail, including any attachments, may be intended solely for the personal and confidential use of the sender and recipient (s) named above. This message may include advisory, consultative and/or deliberative material and, as such, would be privileged and confidential under HIPAA regulations and not a public document. Any information in this fax/e-mail identifying a student of Cape Cod Community College is confidential. If you have received this fax/e-mail in error, you must not review, transmit, convert to hard copy, copy, use or disseminate this fax/e-mail or any attachments to it and you must delete this message. You are requested to notify the sender by return e-mail. Thank you.

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