Fax COVERSHEET from: NAME of Center\_

|  |  |  |  |
| --- | --- | --- | --- |
| Contact Name: |  |  |  |
| Address of Center: |  |  |  |
| Center Phone: |  |  |  |
| Center Fax: |  |  |  |
| NAME OF rECIPIENT: |  |  |  |
| fAX: |  |  |  |
| pHONE: |  |  |  |
|  | **RE: Request for Health Records** |  | Date: |
| Total Pages: | | | |

Please fax the following documents to the attention of ­­­­­­­­

(Contact Name) (Fax Number)

\_\_ Immunization Record

\_\_ Most recent EPSDT Physical

\_\_ Special care plan for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ HGB/HCT results and lead results

\_\_ Other

For \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Child’s Name) (Date of Birth)

Comments:

See attached letter and parent/guardian consent.

Thank you.