CENTRAL PHOENIX MEDICAL CLINIC L.L.C.

To: Existing and New Patients

From: Barbara A. Berry, M.D.
Barbara C. Lipschitz, M.D.
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Re: Immunizations Records

Greater emphasis has been recently placed on the duty of medical care providers to maintain accurate and updated records for each patient as they relate to their immunizations. To better serve you, we ask that you provide our office with proof of immunizations previously received. This information will be applied to your permanent file and will be referred to in determining additional needs and requirements in your immunization status.

Unfortunately, we are not allowed to make this an option in our data collection; therefore, please make a choice from the following statements:

1. I have an immunization record, and I will provide a copy within 2 weeks of signing this letter.

   Print Name: _____

   Signature: _____ Date: _____

2. I do not have an immunization record available (Adults Only) but I attest that I am current in my immunizations.

   Print Name: _____

   Signature: _____ Date: _____

3. I do not know if I am current, nor do I have records of my immunizations.

   Print Name: _____

   Signature: _____Date: _____

*Adults must have proof of Tetanus within 10 years;
**IF NOT, guidelines indicate revaccination is warranted