Authorization To Release Immunization Records

Lawrence County Health Department
2419 Mitchell Road
Bedford, IN 47421
Phone 812-275-3234 Fax 812-275-3088

Instructions:

1. Complete **ALL** portions of this form
2. Please sign and send to above address, with following items:
   a. ID (current driver's license, current State ID or current passport).
   b. Money order or Cashier's check for each record, **$2.00 each**
   c. Self addressed, stamped envelope
   d. If Guardian, send guardianship papers (see box 6)

1. Patient's Name: _____ (first name) (middle name) (last name)	2. Date of Birth:

3. List any other name patient might be found by:

4. Mother's full name: _____ (first name) (middle name) (last name) (maiden name)

5. Father's full name: _____ (first name) (middle name) (last name)

6. Relationship to patient whose record is being requested: (check one)

☐ Person named on record (must be 18) ☐ Parent(s) of person named on the record

☐ Legal Guardian of person named on the record (include original guardianship papers with raised court seal)

7. I request and authorize the Lawrence County Health Department to release immunization information in the Children and Hoosiers Immunization Registry Program system to the person or agency named below. Requested information will be faxed (if long distance number, additional $2.00 fee) or mailed (provide addressed, stamped envelope) to the below designated number or address as soon as possible, but no later than 10 working days after receipt of this signed authorization.

RECEIVING AGENCY INFORMATION

Person or agency to receive records: _____

Fax Number: _____ Phone number: _____

Address: _____ City_____ State_____ Zip_____

This authorization expires 60 days after it is signed. A copy of this document is considered the same as the original.

I further understand that I may revoke this authorization at any time by notifying the releasing organization in writing, but if I do it will not have any effect on any actions that were taken before my revocation is received.

By signing this authorization, I acknowledge that I have read and understand this authorization. I understand that immunization records to be disclosed will be disclosed in accordance with this authorization.

I declare under the penalty of perjury under the laws of the State of Indiana that the foregoing is true and correct, and that I am authorized to sign this release on the patient's behalf.

_____ _____ _____
(signature of patient/parent or legal guardian) (relationship to patient) (date)

_____ _____
(print name on signature) (e-mail address)