Authorization to Release Immunization Records

INSTRUCTIONS:

1. Complete ALL portions of this form.
2. Email completed form with signature and a copy of a government issued ID with your signature to be compared to the signature on this form to medicalrecords@gcph.info

Patient's Name: _____ _____ _____
first name *last name* *middle initial*

Date of Birth (month, day, year): _____ Previous Name(s): _____

Parent or Guardian (if under age 18): _____

Contact Number: _____ Request Date: _____

Person, agency or facility to receive records: _____

Mailing Address (number and street): _____

City: _____ State: _____ Zip Code: _____

Email: Fax Number:

Choose a method of delivery of records by checking the corresponding box: ☐ Fax ☐ Email ☐ U.S. Mail

This authorization remains in effect:

☐ From the date of this Authorization until _____ (not longer than 60 days).

☐ Until Greene County Public Health fulfills the request or 60 days from the date this Authorization is signed, whichever occurs first.

I hereby authorize Greene County Public Health to release the immunization records of the Patient identified above contained in ImpactSIIS ("Immunization Records"), which may include, without limitation, name, address, social security number, date of birth, race, and ethnicity demographics, mother's maiden name, types, and dates of immunizations, name and address of the provider administering each dose, any and all adverse reactions to any immunization, insurance coverage information, and existence of any medical or religious exemptions of the above for which data is being collected.

I understand that my information may not be protected from re-disclosure by the requestor of the information unless otherwise provided for by state or federal law.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not granted.

By my signature below (or by typing my name below), I hereby attest that (i) I am the Patient identified above or the parent or legal guardian of the Patient identified above, (ii) I authorize the release of immunization records for the Patient identified above to the Recipient specified above and (iii) I fully understand the meaning of this authorization. A photo static or facsimile copy of this authorization is valid as the original.

_____ _____ _____
Signature of patient/parent or legal guardian *relationship to patient* *Date*