Authorization to Release Immunization Records

Patient's Name: ____ Date of Birth: ____________________

Previous Name(s): ______________________Parent or Guardian (if under 18): ______________________

Phone Number: ________________Person or facility to receive records: ____________________________

Mailing Address (number and street): ____

City: ____ State: ________ ZIP code: ______________

Choose a method for delivery of records: ☐ Pick up ☐ Fax ☐ Email ☐ Mail

Person Picking up (if someone other than patient): ____

E-mail: ____ Fax: ________________________________

This Authorization remains in effect:

☐Until the Jersey County Health Department fulfills the request or 60 days from the date this Authorization was signed, whichever occurs earlier.

I hereby authorize the Jersey County Health Department(JCHD) to release the immunization records of the Patient identified above contained in I-CARE ("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:

- The information disclosed pursuant to this Authorization may be subject to redisclosure by the Recipient and may no longer be protected by applicable federal or Illinois law. JCHD cannot guarantee that the Recipient will not re-disclose the immunization information provided to a third party. The third party may not be required to abide by this Authorization or applicable federal or Illinois law governing the use and disclosure of health information.
- I have the right to revoke this Authorization in writing at any time. The revocation will be effective immediately except to the extent that the Jersey County Health Department acted in reliance on this Authorization before it received the written notice of revocation.
- This Authorization will remain in effect until the term of the Authorization expires or a written notice of revocation is received by the JCHD.
- I may be contacted by JCHD for additional information if the records of the Patient identified above cannot be identified based on the information provided.
- JCHD may require identity verification utilizing a secure and encrypted electronic transmission to me, as the patient identified above. 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 the 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)