AUTHORIZATION TO RELEASE INFORMATION
THROUGH THE ILLINOIS IMMUNIZATION REGISTRY

I hereby authorize **IDPH**
(name of immunization provider or learning institution) to release information concerning immunization records, including but not limited to 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 _____
(insert names of all adults(18+) for which data is being collected) (the Immunization Records@) to the Illinois Department of Public Health (the Department@) for inclusion in a centralized database of immunization records.

I also authorize the Department to consolidate into the Immunization Registry the following historical records of my childhood (the Historical Records@): (i) any Immunization Records that were collected by the Department from public providers of immunizations that are now contained in the Cornerstone data repository, (ii) any records maintained by the Department in connection with blood level screening under the Lead Poisoning Prevention Act and (iii) any other health-related data that has been collected by the Department.

I understand that by authorizing the release of my Immunization Records and Historical Records to the Immunization Registry, I am authorizing their release to government health departments, public vaccine providers, community health centers, the Centers for Disease Control and Prevention, and any other person or entity providing immunization services or approved by the Department (the "Recipients") as needing to know my health or immunization status.

I authorize the Recipients and the Department to use the Immunization Records and the Historical Records that will be maintained in the Immunization Registry to provide immunization services, to monitor my immunization status, to promote adherence to recommended immunization schedules, to prepare statistical reports on immunization status of groups of patients in which neither myself nor any other patient may be individually identified and to otherwise monitor and promote the health in Illinois generally.

I also understand that my decision to have my Immunization Records and Historical Records contained in the Immunization Registry is voluntary, and that no immunization or other medical treatment is conditioned upon my Immunization Records being contained in the Immunization Registry.

I also understand that I may revoke this authorization at any time, but that revoking this authorization will not cancel any release of Immunization Records or Historical Records made before I revoke the authorization. I also understand and agree not to hold **IDPH**
(name of immunization provider or learning institution) , the Department or the Recipients liable for release of any Immunization Records or Historical Records that was done in accordance with the terms of this authorization.

English is my primary spoken and written language and I fully understand the meaning of this authorization. A photo static or facsimile copy of this authorization is valid as the original.

Printed Name of Patient _____

Date of Birth _____

Signature _____

Signature of Witness _____

Date _____