AUTHORIZATION TO RELEASE IMMUNIZATION RECORDS

Illinois Department of Public Health, Immunization Section
I-CARE: Illinois Comprehensive Automated Immunization Registry Exchange

INSTRUCTIONS: 1. Complete ALL portions of this form.
2. Please fax completed form with signature to 217-524-0967
3. If you have any questions, please call the Immunization Section at 217-785-1455

Patient's Name: _____
(*First name*) (*Last name*) (*Middle initial*)

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

Parent or Guardian (*if under eighteen (18)*): _____

Contact Number: _____ Request Date: _____

I hereby authorize the Illinois Department of Public Health (IDPH) 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 the above for which data is being collected

In addition, I authorize the Department to consolidate into the Immunization Registry the following historical records of my childhood: any Immunization Records that were collected by the Department from public providers of immunizations; any records maintained by the Department in connection with blood level screening under the Lead Poisoning Prevention Act; and 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.

RECEIVING PERSON/AGENCY INFORMATION

Person, agency or facility to receive records: _____

Mailing Address (number and street):_____ City _____State ____ Zip code _____

Fax Number: (___) _____

Email Address if unable to obtain information requested_____

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.

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.

_____ _____

(Signature of patient/parent or legal guardian) *(Relationship to patient)*

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, 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.