AUTHORIZATION TO RELEASE CHILD'S INFORMATION THROUGH THE ILLINOIS IMMUNIZATION REGISTRY

I hereby authorize **IDPH**
(name of immunization provider) 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

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(insert names of all children 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 children's immunization records.

I also authorize the Department to consolidate into the Immunization Registry the following historical records of my child (the Historical Records): (i) any Immunization Records of my child 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 of my child that has been collected by the Department.

I understand that by authorizing the release of my child's 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 as needing to know the health or immunization status of my child (the "Recipients").

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 my child, to monitor my child's immunization status, to promote adherence to recommended immunization schedules, to assist in the preparation of vaccination documentation required by my child's school, to prepare statistical reports on immunization status of groups of patients in which neither my child nor any other patient may be individually identified and to otherwise monitor and promote the health of my child and children in Illinois generally.

I also understand that my decision to have my child's Immunization Records and Historical Records contained in the Immunization Registry is voluntary, and that no immunization or other medical treatment of my child is conditioned upon my child's 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. Unless I revoke this authorization, this authorization is effective from the date of my signature through my child's 18th birthday.
I also understand and agree not to hold **IDPH**
(name of immunization provider) , 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 photostatic or facsimile copy of this authorization is valid as the original.

Name of Child _____

Date of Birth _____

Name of Parent/Legal Guardian _____

Signature of Parent/Legal Guardian _____

Signature of Witness _____

Date _____