State of Illinois
Illinois Department of Public Health

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. Upload completed form with signature to: https://app.smartsheet.com/b/form/2df9717628b84e06a0bfc539ee4b7f38

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: _____

Person, agency, or facility to receive records: _____

Mailing Address *(number and street)*: _____

City: _____ State: _____ ZIP Code: _____

E-mail: _____ Fax Number: _____

Choose a method of delivery of records by checking the corresponding box below:

☐ Fax ☐ E-mail ☐ U.S. Mail

This Authorization remains in effect:

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

☐ Until the Illinois Department of Public Health fulfills the request or 60 days from the date of this Authorization is signed, whichever occurs earlier.

I hereby authorize the Illinois Department of Public Health 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. The Illinois Department of Public Health 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 Illinois Department of Public Health 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 Illinois Department of Public Health.
- I may be contacted by the Illinois Department of Public Health for additional information if the records of the Patient identified above cannot be identified based on the information provided.
- The Illinois Department of Public Health 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)*