Public Health
Prevent. Promote. Protect.

# Board of Health
## Sidney-Shelby County

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Health Commissioner

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## AUTHORIZATION TO RELEASE IMMUNIZATION RECORDS

A COPY OF THIS COMPLETED ORIGINAL DOCUMENT IS CONSIDERED THE SAME AS THE ORIGINAL

### Child/Client Information:

First Name | Middle Name | Last Name | Date of Birth

### Parent/Guardian Information (person requesting the information):

Parent/Guardian Full Name (if person is less than 18 years old) | Phone Number

### I request and authorize the Sidney-Shelby County Health Department (SSCHD) to release immunization information for the person listed above to the person or agency named below:

First and Last Name | Agency (if applicable)

### Records requested by email, fax or postal mail will be sent in 3-5 business days after receipt of signed authorization. Choose all that apply:

- ❒ Pick up at SSCHD: _____
  Person Picking up Record
- ❒ Mail Record to: _____
  Mailing Address, City, State and Zip Code
- ❒ Fax Record to: _____
  Fax Number

**X** _____

**Signature** | **Relationship to Child/Client** | **Date**

**FOR OFFICE USE ONLY:**

Date Received: _____ Date Completed: _____ Initials: _____