Public Health
Prevent. Promote. Protect.

Board of Health
Sidney-Shelby County

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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: _____