



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

☐ Encrypted Email: _____
Email Address

X

Signature Relationship to Child/Client Date

FOR OFFICE USE ONLY:

Date Received: _____ Date Completed: _____ Initials: _____