AUTHORIZATION FOR RELEASE OF PATIENT IMMUNIZATION RECORD

The undersigned hereby authorizes the Kentucky Immunization Registry

Whose address is: 275 E. Main Street HS2E-B Frankfort, KY 40621

To release to: _____
Individual/Facility Name

Information from the patient/clinic record of:

_____
Full Name (First, MI, Last)

____/_____/_____(_____)_____-_____
Birth date Phone Number

_____
Address

_____
Email Address

All immunization history information may be released, for the purpose of:

_____

Method of Record Delivery if found (choose one option below):

- ☐ Mail immunization records to the above address
- ☐ Fax immunization records to: (_____)_____-_____
- ☐ Send encrypted e-mail to: _____

I understand that this authorization will expire within 30 days from today.

I understand that my information may not be protected from re-disclosure by the requester of the information.

I also understand my refusal to sign this authorization may result in the request being denied.

Signature of Client/Patient, Parent or Legal Guardian **Date**

Relationship (if signature is not patient/client)

Signature of Witness **Date**
(Only required when client/patient, parent or legal guardian signs by mark)