AUTHORIZATION FOR RELEASE OF IMMUNIZATION INFORMATION

Patient Name: ____________________

Date of Birth: ____/____/________

Mother's Maiden Name: ____________________

Street Address: ____________________

City/State/Zip: ____________________

Note: *If the patient is over the age of 18 years, the person requesting the information must be the patient or personal representative of the patient.*

I, the undersigned, hereby authorize the Kansas Department of Health and Environment (KDHE) to release all medical records and information in his/her/their possession which pertain to the immunization status of the patient named above to:

Name ***OR*** Organization: ____________________

Street Address: ____________________

City/State/Zip: ____________________

Phone Number: ____________________

E-Mail Address: ____________________

Fax Number: ____________________

Please indicate the method of release.

Mail E-mail Fax In Person

My KS Health Portal

Note: *This is not an option if records are being released to an organization.*

Please indicate which type of record you are requesting.

All Immunizations Covid-19 Only Both

This authorization will automatically expire one (1) year from the date signed. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon.

____
Signature (Patient, Parent, Personal Representative)

____
Printed Name (Patient, Parent, Personal Representative)

____
Relationship to Patient

____/____/________
Date

If you are the Personal Representative of the patient, please provide the required documentation from the list below.

Guardian - copy of Court Appointment

Treatment Monitor/Rogers Guardian - copy of Court Appointment

Health Care Agent - copy of Health Care Proxy

Department of Children & Families (DCF) or Contractor of DCF - copy of Authorization for Release of Confidential Information

Return completed form with a copy of your government issued identification to:

KSWebIZ – Immunization Program KDHE – BDCP
1000 SW Jackson, Suite 210 Topeka, KS 66612-1373
Fax - 785-559-4227
Email - KDHE.ImmunizationRegistry@ks.gov

FOR INTERNAL USE ONLY

Match Found: YES NO

If Yes, Patient ID: ____________________

Method of Release: FAX E-MAIL MAIL PORTAL IN PERSON

Photo ID Information

State or Country: ____________________

Number: ____________________

Expiration: ____________________

____
Staff Completing Request

____/____/________
Date