AUTHORIZATION FOR RELEASE OF IMMUNIZATION INFORMATION

On this ________ day of ____________________, 20__, 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 ________________________, against childhood diseases. The records and information to be released are mine or my child's/ward's. (I have attached to this release the documentation which authorizes me to act on behalf of my ward.) Said information and records are to be released to:

Name: ____

Address: ____

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Phone: (_____) ____________________________________

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

Patient Name: ______________________________________

Address at birth: ______________________________________

____

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Date of Birth: _____/____/________

Social Security Number: ______ - ____ - _______

Mother's Maiden Name: ______________________________________

Home Phone number: (_____) - _______________

___________________________________ ___________________________

Patient's/Parent's/Guardian's Signature Date

For internal purposes only:

Note: If the patient is over the age of 18 years, the person requesting the information must have a signed authorization from the patient or the person must be the legal guardian of the patient and present Letters of Guardianship which have been certified by the District Court supervising the case.

Program Staff processing request: _____________________________ Date:________________

Match Found Yes No If Yes, Patient ID: _________________________

Method of Release: Faxed Mailed Hand Delivered

Mail to: KSWebIZ – Immunization Program
KDHE – Bureau of Disease Control & Prevention
1000 SW Jackson, Suite 210
Topeka, KS 66612-1274