AUTHORIZATION TO RELEASE IMMUNIZATION RECORDS

State Form 52665 (5-06)

Indiana State Department of Health, Immunization Program
Children and Hoosiers Immunization Registry Program (CHIRP)

CHIRP
Children and Hoosiers Immunization Registry Program

INSTRUCTIONS:
1. *Complete ALL portions of this form*
2. *Please sign and fax to 317-233-8827*
3. *If you have any questions please call the CHIRP Support Center at 888-227-4439*

Patient's Name: _____
(last name) *(first name)* *(middle name)*

Date of Birth: _____ Previous Name(s): _____

Parent or Guardian (if under 18): _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Social Security Number*: _____

I request and authorize the Children and Hoosiers Immunization Registry Program to release immunization information in the Children and Hoosiers Immunization Registry Program system to the person or agency named below. Requested information will be faxed, mailed, or emailed to the below designated number or address as soon as possible, but no later than 10 working days after receipt of this signed authorization.

RECEIVING AGENCY INFORMATION

Person or agency to receive records: _____

Fax Number: _____ Phone Number: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Person or agency email address: _____

This authorization expires 60 days after the date it is signed. A copy of this document is considered the same as the original.

I further understand that I may revoke this authorization at any time be notifying the releasing organization in writing, but if I do it will not have any effect on any actions that were taken before my revocation is received.

By signing this authorization, I acknowledge that I have read and understand this authorization. I understand that immunization records to be disclosed will be disclosed in accordance with this authorization.

I declare under the penalty of perjury under the laws of the State of Indiana that the foregoing is true and correct, and that I am authorized to sign this release on the patient's behalf.

Signed on _____ at _____
(month/day/year) *(city and state where signed)*

_____ _____
(signature of patient/parent or legal guardian) *(relationship to patient)*

* This Agency is requesting your Social Security Number in accordance with IC 4-1-8-1. Disclosure is voluntary and you will not be penalized for refusal.

Notice: The Children and Hoosiers Immunization Registry Program keeps a record of immunizations that are entered into the Children and Hoosiers Immunization Registry Program system by participating providers, health plans, vital records, and Medicaid. You may ask us for a copy of your record or your children's record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. To obtain your immunization record, we recommend you first check with your provider's office. If they are unable to provide a copy of your complete immunization history, please contact the Children and Hoosiers Immunization Registry Program Support Center at 1-888-227-4439.