COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

AUTHORIZATION FOR RELEASE OF IMMUNIZATION RECORDS

I hereby authorize the Pennsylvania Department of Health to release information/records in its Pennsylvania Statewide Immunization Information System (PA-SIIS) files relating to immunizations received by:

Name of person/minor whose information is being released:

_____

Date of Birth: _____

Address: _____

_____

Phone: _____

Email (optional): _____

I authorize the information/records to be sent to:

_____
(name of person or agency to whom records are to be released)

_____
(address of person or agency to whom records are to be released)

_____
(email of person/agency to whom records are to be released)

_____
(phone number of person/agency to whom records are to be released)

I understand that the information/records released pursuant to this authorization will include all immunizations/vaccinations reported to the Pennsylvania Department of Health and entered into PA-SIIS and maintained in PA-SIIS.

I understand that this authorization will remain valid for one year following the date of my signature, unless revoked earlier by me in writing, except to the extent that the Department has already acted upon my authorization.

I understand that my electronic signature or my electronically printed name in the signature block of this form, along with the electronic submission of this form, attests that I am consenting to the release of the information/records listed above and that I have authority to authorize that release.

Signature of Person Authorizing the Release of Information/Records:

_____

Relationship to person whose information/records are being released (if self, indicate "Self"):

_____

If signature is other than the person whose information/records are being released:

Print Name: _____

Address: _____

_____

Phone: _____

Email: _____

DATE: _____

Preferred method for records to be sent by: Email:_____ U.S. Mail*_____

Please e-mail this completed form, **along with a copy of your photo I.D**. to: RA-DHVaxRecords@pa.gov

If you are unable to e-mail the form, please send the completed form, **along with a copy of your photo I.D**. to:

Division of Immunizations
PA Department of Health
Room 1026, Health & Welfare Bldg.
625 Forster St.
Harrisburg, PA 17120

*Please note that processing times will be longer for requests sent by mail.