VACCINE/IMMUNIZATION
REQUEST ONLY
Fax or Email

I hereby authorize a copy of my child's vaccine record to be released **FROM**:

Indianapolis Independent Pediatricians, PC
777 Beachway Drive, Suite 210, Indpls, IN
Tel: 317-293-7177 Fax: 317-293-3991
Email: iip@indypeds.com

Patient Name(s):____ Date of Birth:______________________

Patient Name(s):____ Date of Birth:______________________

Type of Information to Disclose: Vaccine/Immunization Record ONLY (No charge)	**The purpose of disclosure is:**

Please Choose ONE:

( ) Please fax the vaccine record to:____

Fax Number:____

( ) Please email the vaccine record to:____

Email Address:____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand revoking will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:______________. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

This information is disclosed from records whose confidentiality is protected by Federal law. Federal Regulations 42CFR, Part 2) prohibits any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. This consent may be revoked at any time, except to the extent that action has already been taken. A general authorization for the release of medical or other information is not sufficient for this purpose. There is a statutory fee associated with the copying/mailing of this information; 760 IAC 1-71-3.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X____ _______________________________________

Signature of Patient (if under 18 years old) / Parent/ Guardian or Authorized Representative **Date**

____ _______________________________________

Printed Name **Relationship / Capacity to patient**

____ _______________________________________

Address **City, State, Zip**

____ _______________________________________

Email Address **Telephone Number**