



Immunization Record Release

Print, fill out and return via mail, in-person, or fax (330)430-7857. **A copy of a photo ID (i.e., driver's license, passport) of the person requesting the information must be presented in person or mailed/faxed with this request.**

Immunization record requested for:

Name (First, MI, Last)	Date of Birth
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Individual requesting immunization record *:

Name (First, Last)	Relationship to patient
Address	Phone Number

*If the patient is a minor, person requesting record must be legal guardian and provide verification.

Pick up in person:**

Individual given permission to pick up the immunization record in person (if not the legal guardian listed above)

Name (First, Last)	Date of Birth
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** Person picking up the immunization record will be required to provide valid photo ID at time of pick-up.

Mail to:

Name		
Address	City	Zip Code

Fax to:

Fax number	Attention to
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I understand I am authorizing Canton City Public Health (CCPH) to release the medical immunization record for the above listed individual and acknowledge CCPH can only verify vaccines administered by CCPH and may not have access to records for vaccines administered by other providers. I understand records from the Ohio Immunization Registry (Ohio ImpactSIIS) may include vaccines not administered by Canton City Public Health.

Signature of patient or legal guardian

Date

Legal Notice to the Recipient: This information has been disclosed to you from confidential records protected from disclosure by state law. We shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law.

Office Use Only

Type of immunization record provided to requester: ImpactSIIS EMR (Insync) HDIS
 Release method: In Person Mail Fax Other _____
 Identification Verified by: Photo ID (Required) Other: _____
 Employee Signature: _____ Date Released: _____

