AUTHORIZATION FOR RELEASE OF IMMUNIZATION INFORMATION

Patient Name: _____

Date of Birth: _____/_____/_____

Mother's Maiden Name: _____

Street Address: _____

City/State/Zip: _____

Note: *If the patient is over the age of 18 years, the person requesting the information must be the patient or personal representative of the patient.*

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 the patient named above to:

Name ***OR*** Organization: _____

Street Address: _____

City/State/Zip: _____

Phone Number: _____

E-Mail Address: _____

Fax Number: _____

Please indicate the method of release.

☐ Mail ☐ E-mail ☐ Fax ☐ In Person

☐ My KS Health Portal

Note: *This is not an option if records are being released to an organization.*

Please indicate which type of record you are requesting.

☐ All Immunizations ☐ Covid-19 Only ☐ Both

This authorization will automatically expire one (1) year from the date signed. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon. I further understand KDHE may update contact information based off of the information provided on this form.

_____ _____

Signature (Patient, Parent, Personal Representative) Printed Name (Patient, Parent, Personal Representative)

_____ _____/_____/_____

Relationship to Patient Date

If you are the Personal Representative of the patient, please provide the required documentation from the list below.

Guardian - copy of Court Appointment

Treatment Monitor/Rogers Guardian - copy of Court Appointment

Health Care Agent - copy of Health Care Proxy

Department of Children & Families (DCF) or Contractor of DCF - copy of Authorization for Release of Confidential Information

Return completed form with a copy of your government issued identification to:

KSWebIZ – Immunization Program KDHE – BDCP
1000 SW Jackson, Suite 210 Topeka, KS 66612-1373
Fax - 785-559-4227
Email - KDHE.ImmunizationRegistry@ks.gov

FOR INTERNAL USE ONLY

Match Found: YES NO

If Yes, Patient ID: _____

Updates made to KSWebIZ: YES NO

Method of Release: FAX E-MAIL MAIL PORTAL IN PERSON

Photo ID Information

State or Country: _____

Number: _____

Expiration: _____

_____
Staff Completing Request

_____/_____/_____
Date

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