RICAIR Immunization Record Release Form
3 Capitol Hill Providence, RI 02908
Phone: 401-222-4644 **Fax:** 401-222-1442
Email: RIDOH.RICAIR@health.ri.gov

AUTHORIZATION TO RELEASE IMMUNIZATION RECORDS

Patient's Name: _____ **D.O.B:** / /

I request and authorize **RICAIR** to release immunization records of the patient named above to the following Healthcare provider or Public Health Agency:

Attention: _____

Name: _____

Street Address: _____

City, State, Zip: _____

This request and authorization will apply to the following information:

Immunization Records _____

This information is to be:

Mailed to address above _____ Faxed to: _____
Fax Number

This authorization and/or request to release information from my RICAIR immunization records is fully understood and is made voluntarily on my part and may include faxing of medical record information. I understand that this disclosure may include sensitive information; and that this consent is subject to revocation at any time except to the extent that action passed on this consent had already been taken. I understand that a photo scan or faxed copy of the consent is as valid as the original.

_____ _____
Printed Name **Relationship to Patient**

_____ _____
Signature **Date**

_____ _____
Witness Signature **Date**