# District of Columbia Immunization Information System (DOCIIS)

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

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MURIEL BOWSER, MAYOR

## Authorization to Release Immunization Record Form

**MAIL TO:** DC Department of Health Immunization Program
2201 Shannon Place SE, 5th Floor
Washington, DC 20020

**EMAIL:** doh.immunization@dc.gov

### SECTION I: Patient Information
*(Record requests expire 30 days after the date the requestor authorized and signed the release form.)*

Patient Name: _____
Last First Middle

Other Name(s) Used: _____ Date of Birth: _____/_____/_____
MM DD YY

Address: _____
Street Apt. City State Zip Code

### SECTION II: Receiving Person or Agency
*(Where to send the official immunization record)*

Person/Agency to Receive Immunization Record: _____

Phone: (____)_____ Fax: (____)_____ Email: _____

Mailing Address: _____
Street Apt. City State Zip Code

Immunizations should be sent to the listed: ☐ Fax ☐ Mailing Address ☐ Secure Email ***OR*** ☐ I will pick up

### SECTION III: Requestor Information
*(All requests MUST be accompanied with a photocopy of requestor's current state issued ID or picture ID)*

Requestor Name: _____
Last First Middle

Phone Number: (____) _____ Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian

Reason for Request: _____

Address: _____
Street Apt. City State Zip Code

Supporting Documentation: ☐ Driver's License ☐ Court Order Granting Guardianship ☐ Non-Driver's ID
☐ Release of Information ☐ Work ID ☐ Student ID ☐ Other: _____

I request and authorize the DC Immunization Program to release this patient's official immunization record from the District of Columbia Immunization Information System (DCOIIS), to the person/agency above. I declare that the foregoing is true and correct, and that I am authorized to sign this release on the patient's behalf. I understand that not all providers in the District submit information to DOCIIS and there is a chance that my child's or my record may not be found in DOCIIS or the record may have incomplete information. I understand that the requested information will be faxed, or mailed to the designated number or address listed above or may be picked up by designated person/agency.

_____ Signed on: _____/_____/_____
Signature of Parent/Legal Guardian or Patient (if 18 years of age or older)

### SECTION IV: For Official Use Only

Received: ____/____/____ ☐ Records Released ☐ Record Not Found ☐ Record Found But No Immunizations Reported

Record Released: ____/____/____ Check One: ☐ Faxed ☐ Mailed ☐ Emailed ☐ Hand Delivered

Processed by:_____