DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

District of Columbia Immunization Information System (DOCIIS)
Authorization to Release Immunization Record Form

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

MAIL TO: DC Department of Health Immunization Program
899 North Capitol Street, NE
Washington, D.C. 20002

FAX TO: (202) 576-6418
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 (DOCIIS), 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 yrs 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:_____