Marion Public Health

181 S. Main St.
Marion, OH 43302
Phone: (740) 387-6520
Fax: (740) 383-2546
Email: certificates@marionpublichealth.org

Authorization for Release of Immunization Records

Parent/Guardian Information:

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Parent/Guardian Full Name **Parent/Guardian Phone Number (Include Area Code)**

Patient/Child Information:

1st Child

____

Patient/Child First Name **Patient/Childs Middle Name** **Patient/Childs Last Name**

____

Patient/Child Date of Birth **Patient/Child Previous Name(s)**

2nd Child

____

Patient/Child First Name **Patient/Childs Middle Name** **Patient/Childs Last Name**

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Patient/Child Date of Birth **Patient/Child Previous Name(s)**

I request and authorize the State of Ohio Immunization Information System to release the system's immunization information For the patient/child/children named above to the person or agency listed here:

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First and last name **Agency (if applicable)** **Phone Number (including area code)**

Records requested by e-mail, fax or mail will be sent no later than 15 business days (usually within 3-5 days) after receipt of Signed authorization. Choose all that apply:

E-mail records to: ____

Fax records to: ____

Mail records to: ____

Mailing address, including apt #, city, state and zip code

I declare under penalty of perjury under the laws of the State of Ohio that this information is true and correct, and that I am The patient or am authorized to sign this release on the patient/child's behalf.

______________________ ______________________ ______________________

Date (mm/dd/yyyy) **Signature of Client, or parent/guardian** **Relationship to Patient/Child**

The PHI (Protected Health Information) contained in this records request is HIGHLY CONFIDENTIAL. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to this client. Any other use is a violation of Federal Law (HIPAA) and will be reported as such.