Fax: 1-888-436-8320 Help Desk: 1-800-578-7889 CAIRHelpDesk@cdph.ca.gov

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Parent/Guardian Name
(if child is a minor): _____ Telephone: _____

City/County where patient was vaccinated: _____

I request and authorize **California Immunization Registry (CAIR)**

Requestor: Please include a copy of a current ID with picture (i.e. current driver's license). If the child is a ward of the court, or you have been given custody of the child, please include a copy of the documentation authorizing you to receive a copy of the records. If you are from a foster care agency please include a copy of your badge with this request. Thank you!

To release healthcare information (immunization records) of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please indicate how you would like to receive your/your child's immunization records by choosing one of the three options below:

☐ Email: _____

☐ Fax: _____

☐ Postal Service: _____

☐ Yes
☐ No

I authorize the release of any records regarding immunizations received to the person(s) listed above.

Patient/Parent/Guardian
Signature: _____ Date Signed*: _____

*THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED.

Internal Use Only: