AUTHORIZATION TO RELEASE IMMUNIZATION RECORDS

State Form 52665 (R / 7-13)

Indiana State Department of Health, Immunization Program Children and Hoosiers Immunization Registry Program (CHIRP)

Hoosiers **Immunization** Registry Program

- INSTRUCTIONS: 1. Complete ALL portions of this form.
 - 2. Please sign and fax to 317-233-8827.
 - 3. If you have any questions please call the CHIRP Support Center at 888-227-4439.

(last name)	(first name)	(middle name)
Date of Birth (month, day, year):	Pre	vious Name(s):
Parent or Guardian (<i>if under eighte</i>	een (18)):	
Address (number and street):		
Dity:	State:	ZIP Code:
elephone Number:		
ne Children and Hoosiers Immuniz	zation Registry Program system to r emailed to the below designated	istry Program to release immunization information in the person or agency named below. Requested number or address as soon as possible, but no late
RECEIVING AGENCY INFORM	ATION	
Person or agency to receive rec	ords:	
Fax Number:	Telephon	ne Number:
Address (number and street):		
City:	State:	ZIP Code:
D	_	
Person or agency email address	»	
his authorization expires sixty (60		A copy of this document is considered the same as
This authorization expires sixty (60 ne original.) days after the date it is signed. A	A copy of this document is considered the same as
This authorization expires sixty (60 he original. further understand that I may revolute to it will not have any effect on an arms signing this authorization, I acknowledges.	b) days after the date it is signed. An object this authorization at any time by actions that were taken before r	A copy of this document is considered the same as the notifying the releasing organization in writing, but my revocation is received.
This authorization expires sixty (60 he original. further understand that I may revolute to it will not have any effect on an any signing this authorization, I acknown and the penalty of perjudents of perjudents and the penalty of perjudents and the penalty of perjudents are considered.	o) days after the date it is signed. An object this authorization at any time by actions that were taken before removed the disclosed in accordance and under the laws of the State of Irr	A copy of this document is considered the same as the notifying the releasing organization in writing, but my revocation is received. Identifying the releasing organization in writing, but my revocation is received. Identifying the releasing organization in writing, but my revocation is received.
This authorization expires sixty (60 he original. further understand that I may revolute to it will not have any effect on an armount of the summunization of the control	bke this authorization at any time by actions that were taken before read and under the disclosed in accordance ary under the laws of the State of Ire on the patient's behalf.	A copy of this document is considered the same as be notifying the releasing organization in writing, but in the revocation is received. Herstand this authorization. I understand that

Notice: The Children and Hoosiers Immunization Registry Program keeps a record of immunizations that are entered into the Children and Hoosiers Immunization Registry Program system by participating providers, health plans, vital records, and Medicaid. You may ask us for a copy of your record or your children's record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. To obtain your immunization record, we recommend you first check with your provider's office. If they are unable to provide a copy of your complete immunization history, please contact the Children and Hoosiers Immunization Registry Program Support Center at 1-888-227-4439.