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

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Mother's Name (if child is a minor): _____ Telephone: _____

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

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

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

County where patient was vaccinated: _____

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 Signature: _____ Date Signed: _____

Requestor: Please include a copy of a current ID with picture (i.e. current driver's license) and a fax number or email address if you would like the records faxed or emailed to you.

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

Internal Use Only

CAIR ID:	
CAIR Staff Name:	
Date:	