TULSA HEALTH Department

AUTHORIZATION TO RELEASE OFFICIAL IMMUNIZATIONS RECORD

INSTRUCTIONS:

1. *Complete all portions of this form.*
2. *Please sign and submit using the "submit" button at the bottom of the page.*
3. *If you have questions, please call THD immunizations at 918-595-4509.*

You must be a Parent or Legal Guardian for the child (under the age of 18) whose record you are requesting. Those over 18 years of age must request their own immunizations records.

IMMUNIZATIONS RECORD REQUESTED FOR

Full Name: _____ _____ _____ Date of birth: _____
Last First Middle Month/Day/Year

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

PERSON REQUESTING RECORDS

(If record is for a minor child)

I am the ☐ Parent, ☐ Legal Guardian Relationship to child: _____

Full Name: _____ _____ _____ Maiden Name: _____
Last First Middle

Phone number: _____ Email: _____

DISCLAIMER & AUTHORIZED SIGNATURE

I understand that my information may not be secure once it leaves the Tulsa Health Department Immunization Registry. I understand that emails sent from the Tulsa Health Department will not be encrypted, and the Tulsa Health Department is not responsible for the protection of my information after emailing it to me as requested.

I, (*print or type name of Person Requesting Records or Parent or Legal Guardian – for a minor)* _____ _____**, authorize the Tulsa Health Department to release the immunization records to me at the email address I provided above. By my signature, I verify that I am the Adult requesting my own records, or the Parent or Legal Guardian of the minor child I am requesting records for, and I release the Tulsa Health Department from all legal responsibility of liability that may arise from this request.**

I give permission for the electronic submission of this form and agree that my typed name below in the signature field is a legally binding signature. This qualifies as my signature and has the same effect as though it was physically signed by me. I authorize the electronic submission of my signature.

Authorized Signature: (*type full name)* _____

If you would prefer to print this form, you may fax it to: (918) 595-4043.

Records requests will be emailed within five (5) business days to the email address provided above.