Elkhart County Health Department

Community Health Nursing
608 Oakland Avenue, Elkhart, IN 46516
Phone: 574-523-2127 / Fax: 574-522-2192
elkhartcountyhealth.org

Public Health
Prevent. Promote. Protect.

Immunization Record Request

Your request will be honored as soon as possible, if the record has been archived please allow 5 to 7 business days from the date the request is received. **PHOTO ID REQUIRED.**

I request an immunization record for:

☐ Myself ☐ My child/children ☐ Step Child/Children (authorization needed) ☐ Other (authorization needed)

First & Last Name of person on record	Date of Birth	EMR #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check mark action preferred:

1. ☐ Print Record for me *__Please note there is a $5.00 charge__ for this (prices subject to change)
2. ☐ MyVaxIndiana Pin number (allows you to print the record yourself free of charge)

For #1 & #2

List your e-mail address below if you would like the information e-mailed to you (please print clearly)*

_____

☐ **Initial in the box confirming the understanding that information sent via e-mail may not be secure.**

3. ☐ Fax records to my doctor's office **Doctor's / Office Name**: _____

   Address: _____ City: _____ State: ___ Zip Code: _____

   Fax# :_(_____) _____ Phone # :_(____) _____

4. ☐ Release my records to Elkhart County Health Department. Fax # 574-522-2192

Information of person completing this form:

Name: _____ Phone: (____) _____

Street Address: _____ City/State/Zip: _____

By signing below I agree to patient confidentiality and I declare under the penalty of perjury under the laws of the State of Indiana that the foregoing is true and correct. I understand that the immunization record to be disclosed will be disclosed in accordance with this authorization and within Indiana Code 16-38-5-3.

I am authorized to view this record as an individual or as the legal guardian of the record I am requesting.

Signature: _____ Date: _____

If sending this request by mail, email or fax please include a copy of your photo ID.

STOP – FOR OFFICE USE ONLY

____ ID verified ____Permission copied & attached ___ Client Paid

Information was: ___ directly given to client ____ Mailed ___ Emailed ___Faxed

COMPLETE MEDICAL RECORDS DISCLOSURE ENTRY Completion Date: _____ Staff Initials:_____