District of Columbia Immunization Information System (DOCIIS)
Authorization to Release Immunization Record Form

MAIL TO: DC Department of Health Immunization Program
77 P Street NE
Washington, D.C. 20002

FAX TO: (202) 576-6418
Email: doh.immunization@dc.gov

Section I Patient Information
(Record requests expire 30 days after the date the requestor authorized and signed the release form.)

Patient Name:_____
Last First Middle

Other Name(s) Used:_____ Date of Birth:_____/_____/_____
MM DD YY

Address:_____
Street Apt. City State Zip Code

Section II Receiving Person or Agency (Where to send the official immunization record)

Person/Agency to Receive Immunization Record:_____

Phone: (____)_____ Fax: (____)_____ Email:_____

Mailing Address:_____
Street Apt. City State Zip Code

Immunizations Should be Sent to the Listed: [] Fax [] Mailing Address [] Secure Email ***OR*** [] I will pick up

Section III Requestor Information
(All requests MUST be accompanied with a photocopy of requestor's current state issued ID or picture ID)

Requestor Name:_____
Last First Middle

Phone Number: (____)_____ Relationship to Patient: [] Self [] Parent [] Guardian Reason for Request_____

Address:_____
Street Apt. City State Zip Code

Supporting Documentation: [] Driver's License [] Court Order Granting Guardianship [] Non-Driver's ID
[] Release of Information [] Work ID [] Student ID [] Other:_____

I request and authorize the DC Immunization Program to release this patient's official immunization record from the District of Columbia Immunization Information System (DOCIIS), to the person/agency above. I declare that the foregoing is true and correct, and that I am authorized to sign this release on the patient's behalf. I understand that not all providers in the District submit information to DOCIIS and there is a chance that my child's or my record may not be found in DOCIIS or the record may have incomplete information. I understand that the requested information will be faxed, or mailed to the designated number or address listed above or may be picked up by designated person/agency.

_____ Signed On:_____/_____/_____
Signature of Parent/Legal Guardian or Patient (if 18 yrs of age or older)

Section IV For Official Use Only

Received:____/____/____ [] Records Released [] Record Not Found [] Record Found But No Immunizations Reported
Record Released:____/____/____ Check One: ___ Faxed ___ Mailed ___ Emailed ___Hand Delivered
Processed by:_____