



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: <input type="checkbox"/> Fax <input type="checkbox"/> Mailing Address <input type="checkbox"/> Secure Email OR <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Guardian Reason for Request _____
Address: _____ Street Apt. City State Zip Code
Supporting Documentation: <input type="checkbox"/> Driver's License <input type="checkbox"/> Court Order Granting Guardianship <input type="checkbox"/> Non-Driver's ID <input type="checkbox"/> Release of Information <input type="checkbox"/> Work ID <input type="checkbox"/> Student ID <input type="checkbox"/> 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: ____/____/____ <input type="checkbox"/> Records Released <input type="checkbox"/> Record Not Found <input type="checkbox"/> Record Found But No Immunizations Reported
Record Released: ____/____/____ Check One: ___ Faxed ___ Mailed ___ Emailed ___ Hand Delivered
Processed by: _____