AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL IMMUNIZATION RECORD INFORMATION

FOR OFFICE USE ONLY

☐ Complete ☐ Incomplete

☐ Updated ☐ File

☐ No Data ☐ RC________

University of Illinois at Chicago
Office of Medical Immunization Records
PO Box 5220
Chicago, IL 60680-5220
Ph: (312) 413-0464 Fax: (312) 355-4481

Name (Please Print): ____

UIN ____

Date of Birth: _____/______/_____ Current Phone No: (_____) ________-____________ Date of Request: _____/_____/______

I authorize the University of Illinois at Chicago Office of Medical Immunization Records to **release** information from my student records as described below *(specify who records will be sent to and choose either postal or FAX delivery.)*.

Postal or FAX Delivery (Please Choose One)

Agency/ Facility/ Person ____

☐ **Postal Delivery**

Address ____

City, State, Zip ____

OR

☐ **FAX Delivery**

Fax: (_____) ________-____________

I UNDERSTAND THE FOLLOWING PROVISIONS:

- I have the right to inspect and receive copies of information to be disclosed.
- I have the right to revoke this consent at any time.
- Revoking this consent shall have no effect on disclosures made before the revocation of consent.
- Any revocation of consent must be submitted in writing to the University of Illinois at Chicago Office of Medical Immunization Records and signed by the person who gave consent.
- **This authorization expires 90 calendar days after it is signed** or upon the following specific date, event or condition:

____

Signature of Student or Consenting Individual: ______________________________ Date: ________________

If signature is not of Student or Consenting Individual, indicate relationship: ______________________________

Signature of Witness: ______________________________ Date: ________________