REQUEST FOR IMMUNIZATION RECORDS

ALL REQUESTS MUST BE ACCOMPANIED BY A VALID DRIVERS LICENSE

Note: when emailing, mailing or faxing the request please attach a photo copy or a picture of your current valid driver's license along with this request.
Incomplete authorization forms will not be processed.

MAIL TO: Gallatin City County Health Department
215 W Mendenhall Room 117
Bozeman, MT 59715 (406)582-3100

FAX TO: (406) 582-3112
EMAIL: hs@gallatin.mt.gov

Section I Patient Information (One form per person please)

Patient Name:

Other Name(s) Used (Maiden or previous married name):

Date of Birth: Sex assigned at birth: ☐ Male ☐ Female

Section II Receiving Information (Who and Where to send the official immunization record)

☐ I will pick up my/my child's immunization record

☐ Please securely email my/my child's immunization record to:

(You will receive a secure email and be asked to create a password to view it.)

☐ Please mail my/my child's immunization record to:

Address:

☐ Please fax my/my child's immunization record to:

Fax number_____

Section III Requestor Information (Name of person requesting the official immunization record)

Requestor Name:

Phone Number: _____ Relationship to the Patient:

Reason for Request:

I request and authorize Gallatin City County Health Department to release my/my child's immunization record from Montana's Immunization Information System (IIS), *imMTrax OR GCCHD's Patagonia Health EMR,* to the person or agency above. I declare the information above is correct and that I am authorized to sign this release on the patient's behalf. I understand that the requested information will be faxed, mailed, securely emailed to the designated number or address listed above or that I may pick up the record in person as indicated above. ***Notice: Records requests expire 30 days after the date the requestor authorized and signed the release form. One authorization form per immunization records request. Future requests will require a new records release form.***

Signature: **Date:**

Signature of Patient (or Parent, Legal Guardian or Managing Conservator for a Child under the age of 18 years)

Section IV For Official Use Only (Staff only)

Date Released: _____ By:

☐ Records Released ☐ Record Not Found