# Montana Immunization Information System Authorization to Release

To obtain your immunization record, first check with your health care provider or your local county health department. If they are unable to provide you with your immunization history, or you are unable to access these organizations, you may complete this form.

**INCOMPLETE AUTHORIZATION FORMS WILL NOT BE PROCESSED**

**Please allow 3 business days for processing**

***MAIL TO:*** Montana DPHHS Immunization Program
P.O. Box 202951
Helena, MT 59620 – 2951

***FAX TO:*** (406) 444-2920
***EMAIL:*** hhsphsiis@mt.gov

## Section I Patient Information

Patient Name: _____
Last First Middle

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

Date of Birth: _____/_____/_____ ☐ Male ☐ Female ☐ *No longer a Montana resident*

Address: _____
Street City State Zip Code

## Section II Receiving Organization Information (Where to send the official immunization record)

Person or Organization to Receive Immunization Record: _____

Phone: (_____)_____ Fax: (_____)_____

Mailing Address:_____
Street City State Zip Code

Immunizations Should be Sent To the Listed: ☐ Fax ☐ Address

## Section III Requestor Information

Requestor Name: _____
Last First Middle

Phone Number:(_____)_____ Relationship to the Patient_____

Reason for Request: _____

Address: _____
Street City State Zip Code

I request and authorize the Montana Immunization Program to release this patient's immunization record from Montana's Immunization Information System (IIS), *imMTrax*, 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 or mailed to the designated number or address listed above.

_____ Signed On: _____/_____/_____

Signature of Patient (or Parent, Legal Guardian or Managing Conservator for a Child) . **Electronic or electronically generated signatures are not accepted**.

## Section IV For Official Use Only

Date Searched/Released: _____/_____/_____ By: _____

☐ Records Released ☐ Record Not Found ☐ Record Found But No Immunizations Reported

***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.***