LFCHD AUTHORIZATION FOR RELEASE OF PATIENT IMMUNIZATION RECORD

The undersigned hereby authorizes the Lexington-Fayette County Health Department
Whose address is: 650 Newtown Pike, Lexington, KY 40508

To release to: _____
Individual or Facility Name

Information from the patient/clinic KYIR record of:

Full Name (First, MI, Last) _____

Date of Birth _____/_____/_____ Phone Number (_____)_____-_____

Full Address: _____

Email Address: _____

Immunization history information may be released: ☐ COVID-19 Records ☐ All Records

For the purpose of: ☐ Personal Use ☐ Other: _____

Method of Record Delivery if found (choose one option below):

☐ Mail immunization records to the above address
☐ I will pickup the record when notified it is ready
☐ Send secure e-mail to above email address

I understand that this authorization will expire within 30 days from today.
I understand that my information may not be protected from re-disclosure by the requester of the information.
I also understand my refusal to sign this authorization will result in the request being denied.

Email completed and signed form to: CovidCardReplacement@LFCHD.org, mail form to: Lexington-Fayette County Health Department, 650 Newtown Pike, Lexington, KY 40508 Attn: Vaccine Replacement Card Request or drop off to above address

Signature of Client/Patient, Parent or Legal Guardian **Date**

Relationship (if signature is not patient/client)

Signature of Witness **Date**
(Only required when client/patient, parent or legal guardian signs by mark)

LFCHD Completion Only:

Date Request Completed: _____ Staff Member Completing Request: _____

☐ Unable to Complete Request Due to No Records Found ☐ Requestor Notified of No Records Found