Arkansas Department of Health
Immunization Registry (WebIZ)
Authorization to Release Official Immunization History

Patient/Client's Name: *(Last)*_____ *(First)*_____ *(Middle)*_____

Date of Birth: *(M)*_____/*(D)*_____/*(Y)*_____ ☐Male ☐Female Mother's Maiden Name: _____

Address: *(Street)*_____ *(City)*_____ *(State)*_____ *(Zip)*_____

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Please indicate where to send this official immunization record.

Send official immunization record by: ☐ Walk-in /In Person ☐ Mail to address below

☐ Fax Number: (_____)_____-_____ ☐ Email: _____

Name/Organization:_____

Address: *(Street)*_____ *(City)*_____ *(State)*_____ *(Zip)*_____

Phone Number: (_____)_____-_____

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Person requesting information please complete this section in full.

I _____ authorize the Arkansas Department of Health to release this patient/client's official immunization record from the Arkansas Immunization Registry (WebIZ).

Address: *(Street)*_____ *(City)*_____ *(State)*_____ *(Zip)*_____

Phone Number: (_____)_____-_____ Email: _____

REQUIRED: A copy of a valid, government-issued, photo identification document of the requestor is required for phone, fax or email requests. No photocopy of photo ID required for walk-in requests.

Signature of Patient/Client: _____ Date: _____

(By signing here I declare I am authorized as either Self, Parent, Legal Guardian or Managing Conservator for a child)

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Privacy Notification: Confidential communications about medical information or medical records from the Arkansas Immunization Information System at the Arkansas Department of Health may be communicated using an alternate means or be delivered using an alternate location. Under federal law 104-191, also known as HIPAA, a person is entitled to request such an arrangement upon written request. Under federal law, we are required to accommodate "reasonable" request for communicating confidential medical to you via alternate means. We may deny your request if we determine that your request is unreasonable. With your request, you agree that the security and confidentiality of your confidential medical information that we send to an alternate address or via an alternate means is your responsibility alone. If we act on your request and send communications as you have specifically directed us to do in writing, you agree that we cannot and shall not be responsible for any inadvertent disclosures that may occur as a result of fulfilling your written request.

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For ADH Office Use Only

Date Searched/Released: _____ ☐ Record Released ☐ Record Not Found

By: _____ ☐ Record Found, but No Immunizations Reported

☐ ID Verified for walk-ins only (no copy of ID required)

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If you have any questions or concerns, please contact the Arkansas Department of Health's Immunization Section at 1-800-574-4040, via email at immunization.section@arkansas.gov or **fax to 501-661-2300**. You may reply by regular mail to your local Arkansas Department of Health clinic or to:

Arkansas Department of Health
Immunization Section, Slot 48
4815 West Markham
Little Rock, AR 72205

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