Authorization to Release Immunization Registry Information

The purpose of this authorization is to obtain a copy of the immunization records designated below.
This authorization is effective for this specific release only. Another release will be required for any future requests.
Complete one form for each individual requesting immunization records.

Release of Information

SECTION 1: DEMOGRAPHICS

Name:

First	Middle	Last	Date of Birth

Name at time of immunization (if different than above).

First:	Middle:	Last:
First:	Middle:	Last:

SECTION 2: DOCUMENT REQUESTED (check all that apply)

- ☐ Personal Immunization Record, DHEC 4025
- ☐ COVID-19 Vaccination Record
- ☒ SC Certificate of Immunization, DHEC 4024 (Only issued by health department and applies to children enrolled in childcare - 12th grade)

SECTION 3: METHOD OF RELEASE (check only one)

☐ In person at health department	Name of Health Department:
☐ *Email – Encrypted ☐ *Email – Non-Encrypted	Email address:
☐ *Mail	Mailing address: Street City/State/Zip:
☒ *Fax	Fax Number: 843-672-3913

*Confidentiality cannot be guaranteed by sending via email, mail, or fax.

Check One: ☐ I would like a copy of this request form. ☐ I do not want a copy of this request form.

SECTION 4: AUTHORIZATION

Check One:
- ☐ This request is for my own records; I am 16 years old or older.
- ☐ This request is for my child's record; I am the parent of a child less than 18 years of age. Relationship: ______________
- ☐ This request is for the person for whom I am legal guardian. Attach a copy of the court order providing custody/guardianship.

If this information is disclosed by me to others, I understand that the information may be re-disclosed by the person that receives it and may no longer be protected by state or federal law. I understand that DHEC may not condition treatment, enrollment, or eligibility for benefits if I refuse to sign this authorization; however, I understand that I may not be eligible for services from some programs if I refuse to allow the release of information needed for treatment payment, enrollment, or eligibility for benefits. I understand that by signing below I authorize the release of the above information to me. Any future requests will require the completion of another authorization. I hereby authorize the South Carolina Department of Health and Environmental Control to disclose and produce to me the above protected health information.

Print Name:	Photo ID attached: ☐
Signature:	Date:

Witness (Only if person requesting records cannot sign or signs with an "X")

DHEC Use Only	☐ Documents released as requested. ☐ Patient not found.	Date Processed:	Staff Initials

Revocation of Authorization

Sign below ONLY to revoke the above release.

I understand that by signing below, I am revoking this authorization as to any information that has not yet been released in reliance upon the authorization.

Signature:	Date:

Witness (Only if person whose records are request cannot sign or signs with an "X")