AUTHORIZATION TO RELEASE PATIENT INFORMATION

This authorization is voluntary.

Patient Name: _____ Date of Birth: _____ Gender: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Phone: (_____)_____ cell/home/work Email: _____

I hereby authorize Shelby County Health Department through its appropriate personnel, to communicate and release the following information through phone, text, un-secure email, or fax:

☐ Immunization Records/Forecasts ☐ MyVaxIndiana Pin Number

☐ Communicable Disease Test Results ☐ Lead Test Results ☐ Covid-19 Test Results

I hereby authorize Shelby County Health Department to communicate and release the information checked above with the following people:

Name	Phone#	Relationship to Patient
1.		
2.		
3.		

I understand that Shelby County Health Department will attempt to verify the identity of those I authorized by seeking confirmation of the answers to **at least 2** of the following questions:

1.) **Birthday of the patient is** _____.
2.) **Name of patient's current pet is** _____.
3.) **Zip code of the patient's mailing address is** _____.
4.) **City in which the patient was born is** _____.
5.) **Patient's mother's maiden name is** _____.

Revoking Authorization: I may revoke this authorization at any time. Revocations must be made in writing and sent to the Shelby County Health Department. Revocations will not apply to information that already has been released.

Effect of release: Once information has been disclosed, Shelby County Health Department can no longer protect it from further disclosure.

SIGNATURE: _____ DATE: _____

NAME (Printed): _____ Relation to Patient: _____