Request to Release Immunization Records from the Colorado Immunization Information System (CIIS)

(Please be aware - requests are completed within 5 business days)

If requesting the release of your OWN immunization record:
I, __________________________________, date of birth ____________________ request the release of my immunization record from CIIS.

If requesting the release of a CHILD’S immunization record:
I, __________________________________, certify that I am the parent, legal guardian, or person with legal custody or decision-making responsibility for the medical care of minors listed below.

Complete the following information for each child's record that are being requested. Please fax this to 720.887.2229 or email it to publichealth@broomfield.org or drop it off in person at 100 Spader Way.

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<tr>
<th>Full Name</th>
<th>Date of Birth</th>
<th>Sex</th>
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Preferred method for release of records:
Pick up: Individual’s name __________________________________________________________________________________________________ Phone number __________________________________________________________________________________________________

Mail: Individual or agency name ____________________________________________________________________________________________ Full Address ______________________________________________________________________________________________________

Fax: Individual or agency name __________________________________________________________________________________________ Fax number ______________________________________________________________________________________________________

Email: Individual’s name __________________________________________________________________________________________________ Email address ______________________________________________________________________________________________________

(Please note that if you choose to have records released by email, it will be encrypted and will require you to follow prompts to verify email in order to open)

I hereby authorize the City and County of Broomfield Public Health to release immunization records for the above listed individuals to myself, college, agency or person(s) listed above.

Signature __________________________________________ Date __________________________

Office Use Only:
Date request received: ______________ Initial:_________ Via: In-person Fax Mail Phone Email

Date records sent: ______________ Initial:_________ Via: In-person Fax Mail Phone Email

Notes: