RiDE Regional Immunization Data Exchange

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth:_____

Mother's Name (if child is a minor):_____ Telephone: _____

I request and authorize **California Immunization Registry – Region IV (RIDE)** to release healthcare information (immunization records) of the patient named above to:

Name:_____

Address: _____

City: _____

State: _____

Zip Code: _____

County where patient was vaccinated: _____

Please indicate how you would like to receive your/your child's immunization below:

Fax #:_____

Email address: _____

Postal Service (Above Address)

I authorize the release of any records regarding immunizations received to the person(s) listed above. Yes No (Please Circle one)

Patient/Parent Signature:_____

Date Signed:_____

Requestor: Please include a copy of a current ID with picture (i.e. current driver's license)

Fax form to 209-462-2019 or email it to support@myhealthyfutures.org

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED.

Internal Use Only

Healthy Futures/RIDE ID:	
Registry Staff Name:	
Date Completed:	