

Amador County Public Health Authorization To Release Healthcare Information



Vaccination records: Prior to submitting this request, please complete the [DIGITAL VACCINE RECORD](#) request form using the telephone number or email address you provided when you received your vaccine. Should you have any trouble receiving your record, proceed with completing this form.

Adults requesting records for adult children, family, spouses, or significant others: Anyone over the age of 18 is responsible for requesting his or her own record. Please have them submit their own request to avoid any delays in processing time, as requests are processed in the order they are received.

Minors requesting immunization records: Please have your parent or guardian request your records. Any requests submitted by a minor will be denied unless you are an emancipated youth and have court documents to show this.

Required fields are marked by an *

Patient Information

| | | | |
|--|---|------|-----------------|
| First Name * Middle Name Last Name * DOB * Gender * Phone * | Relationship To Patient * <table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 50%;">Self</td> <td style="width: 50%;">Parent/Guardian</td> </tr> </table> Name of Parent/Guardian (if patient is a minor *) First Name: Last Name: Phone * | Self | Parent/Guardian |
| Self | Parent/Guardian | | |

Requestor Information

| | |
|---|--|
| Name * Address * City * Zip Code * | Please indicate below how you would like to receive your/your child's immunization record sent (choose 1 method only) <div style="text-align: center;"> <input type="checkbox"/> Pick up in person <input type="checkbox"/> Mailed </div> |
|---|--|

Requestor: Please include a copy of a current **valid** government-issued ID with picture (i.e. current driver's license). If the child is a ward of the court, or you have been given custody of the child, please include a copy of the documentation authorizing you to receive a copy of the records. If you are from a foster care agency please include a copy of your badge with this request.

Mail or Bring To: Amador County Public Health, 10877 Conductor Blvd., Suite 400, Sutter Creek, CA 95685

Electronic Signature

By checking this box and by entering your full name below, you are declaring under penalty of perjury under the laws of the State of California that you are the Patient or Parent/Guardian of the patient and are therefore authorized to access the patient's immunization record.

Full Name *

Date

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

For any questions regarding these Disclosure and Share Policies, contact the [Amador County Public Health Department \(209\)223-6407](#).