



## Authorization for Release of Immunization Record

### Instructions

Print PDF form and complete with dark-colored pen. Print in all fields except where a signature is requested.

Submit completed form:

- By fax to (702) 759-1455
- By mail to Southern Nevada Health District, Immunization Program, P.O. BOX 3902, Las Vegas, NV 89127
- By email to [snhdpublicinformation@snhdmail.org](mailto:snhdpublicinformation@snhdmail.org). **Note:** The completed form must be scanned and emailed as a PDF or JPG file.

### Important Information

- The Authorization for Release of Immunization Record is only required for people seeking a copy of their records without getting a vaccine at the health district. All clients who get shots at the health district receive a copy of their immunization records.
- The health district can only provide vaccine information for immunizations entered into the Southern Nevada Health District or Nevada State Registries.
- The \$.60 cent per page cost for immunization records is waived in August.



**Authorization for Release of Immunization Record**

**You must be a parent or legal guardian for the child whose record you are requesting or of legal age to obtain your own immunization record.**

*Fill out the information below, sign, date, and return by mail, fax, or email:*

I, \_\_\_\_\_, of legal age or parent or legal  
Applicant or Parent/Legal Guardian (Please Print)

Guardian of a minor child, hereby authorize and request the Southern Nevada Health District release the immunization records pertaining to me or my minor child:

\_\_\_\_\_  
Patient First Name                      Patient Last Name                      Date of Birth                      Sex

INDICATE HOW YOU WOULD LIKE TO RECEIVE THE RECORD (CHOOSE ONE)

To me via:

\_\_\_\_\_ Pick-up in person

\_\_\_\_\_ Mail to: \_\_\_\_\_

\_\_\_\_\_ Email to: \_\_\_\_\_

\_\_\_\_\_ Faxed to: \_\_\_\_\_

\_\_\_\_\_ To My Doctor: \_\_\_\_\_ at: \_\_\_\_\_

\_\_\_\_\_ To My Child's Doctor: \_\_\_\_\_ at: \_\_\_\_\_

\_\_\_\_\_ To My Child's School: \_\_\_\_\_  
School Name                      Telephone                      Fax Number

I agree to release the Southern Nevada Health District and all its employees from all legal responsibility and liability that may arise from releasing the immunization or medical information I have authorized above.

\_\_\_\_\_  
Signature of applicant or parent/legal guardian                      Date                      Telephone

\_\_\_\_\_  
Witness                      Date