Ohio Department of Health

Authorization to Disclose Immunization Information

Name of Child _____ Date of Birth _____

I, _____, as the parent of guardian of the above named child, hereby authorize (*Name of Provider[s])*

_____

_____
to disclose the specific and individually identifiable immunization records of the above named child to (*Name of School)*:

_____
for the specific purpose of presenting written evidence, satisfactory to the person in charge of admission, that the above named child has been immunized by a method of immunization approved by the department of health as required by section 3313.671 of the Ohio Revised Code.

This authorization will expire upon the presentation of written evidence sufficient to comply with section 3313.671 of the Ohio Revised Code or for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time and that I may be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken by the above named Provider(s) or School in accordance to this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information unless otherwise provided for by state or federal law. Please note: medical records provided to schools that receive federal funding are protected by the Family Educational Rights and Privacy Act (FERPA).

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given.

I also understand that my refusal to sign this authorization may prevent the school from verifying that the above named child has been immunized. I further understand that if the school cannot verify and I cannot provide satisfactory written evidence that the above named child has been immunized, the child may be excluded from school pursuant to section 3313.671 of the Ohio Revised Code.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Relationship / Authority)*

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NOTE: This Authorization was revoked on:	_____	_____
	(Date)	*(Signature of Staff)*

Last reviewed: December 2014

Ohio Department of Health

REVOCATION SECTION

I do hereby request that this authorization to disclose immunization information of _____
(Name of Child/Patient)

signed by _____ on _____ be rescinded,
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

effective _____.
(Date)

I understand that any action taken by the named Provider(s) or School in accordance to this authorization prior to the revocation date is legal and binding.

_____ _____ _____ _____
(Signature of Client/ Patient) *(Date)* *(Signature of Witness)* *(Date)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Relationship/ Authority)*

Last reviewed: December 2014