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TULARE COUNTY
HEALTH & HUMAN SERVICES AGENCY
Patrick J. Hamblin • Compliance, Privacy, & Security Officer

Timothy W. Lutz, MBA
Agency Director

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use this Form for Vaccination Records ONLY

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of Client: _____ Date of Birth: _____

Vaccination Location: _____

Date of First Dose: _____ Date of Second Dose: _____

RELEASE FROM PROVIDER (If you received the COVID-19 vaccination from another provider, please contact that provider or the California Department of Public Health: https://cairforms.cairweb.org/AuthorizationToRelease/AuthorizationToRelease)

Name/Entity: Tulare County Immunizations Program

Address: 1150 South K Street, Tulare, CA 93274

Phone: (559) 685-5725 Fax: _____

Email: PHimmunizations@tularecounty.ca.gov

RELEASE TO PATIENT OR PARENT/GUARDIAN

Full Name: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

PROTECTED HEALTH INFORMATION TO BE DISCLOSED

☐ All vaccine records.

PURPOSE

☐ At the request of the patient/patient representative, parent, or guardian.

EXPIRATION

This authorization expires on _____.
(Enter a specific date)

MY RIGHTS

I may revoke this authorization at any time, but I must do so in writing and submit it to the clinic providing my health services or to Tulare County Health and Human Services Agency Attn: Office of Compliance, 5957 S. Mooney Blvd., Visalia, CA 93277. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law. I have a right to receive a copy of this authorization.

DISCLAIMER

If you are looking for your COVID-19 vaccination record, please allow at least 2 to 3 weeks after your vaccine is administered to complete this form. Once your record is available in the state CAIR system and released, the record will not arrive in an official letterhead nor will you receive a replacement card. If you lose your original CDC vaccination card, it will not be replaced. Additionally, the record you receive will contain ALL immunizations stored in your immunization record in CAIR. We are unable to produce a record that only contains COVID-19 vaccine doses.

SIGNATURE

Signature: _____ Date: _____

Print Name: _____

If signed by other than client, indicate relationship: _____

Submit by Email