Vaccination Records Request Form

Maryland's Immunization Information System (ImmuNet) is a secure web-based registry operated by the Center for Immunization at the Maryland Department of Health (MDH). ImmuNet information is confidential, HIPAA and FERPA compliant, and available only to authorized provider users, and will not be released to third parties without written consent. Authorized provider users can refer to this webpage to access their patients' records.

Please provide complete information below to access/receive vaccination records. An email, fax number, or address (to send the record to) is required for a prompt response. Clients 18 years and older must request their own records (i.e. fill out their own form).

Client's Information

_____

First Name | Middle Name | Last Name

_____ _____

Maiden Name (if applicable) | Mother's Maiden Name

_____ _____

Date of Birth | Sex

_____

Address | City | State | Zip Code

(____)_____ _____

Phone number (Home / Cell) | Email address

To help find/match the records, please list other known names/addresses/phones which may be associated with the client's Maryland vaccination records.

_____

_____

_____

Requestor's Information

Information about the person completing the record request (this information will be used to contact you if this form is incomplete/unclear, or if more information is needed to match the record and will be filed as legal documentation of the record request). Clients 18 years and older must request their own records (i.e. fill out their own form).

Relationship to client(s):

☐ Self ☐ Parent ☐ Legal Guardian ☐ Healthcare Provider

☐ Other Person in Custodial Relation to Client(s) – what is the purpose for requesting access to the client(s) record? _____

_____

Requestor's First Name | Requestor's Middle Initial | Requestor's Last Name

☐ Same as Client's Information above (if not, please provide the information below)

_____

Requestor's Address | City | State | Zip Code

(____)_____ _____

Requestor's Phone number (Home / Cell) | Requestor's Email address

Select ONE method to receive records (*if you select more than one method, the first selected method will be used to send the record*):

☐ Secure email records to: _____

☐ Fax records to: (____)_____

☐ Mail records to: _____

Address | City | State | Zip Code

Please be aware that your information may not be secure once it leaves ImmuNet. If you ask for it to be sent to a third party not covered by privacy laws, that party may disclose it to others. MDH is not responsible for the protection of your information after sending it.

Requestor's Agreement/Signature

☐ By checking this box, I declare under penalty of perjury under the laws of the state of Maryland that this information is true and correct, and that I am the client, or parent, legal guardian, healthcare provider, or other person in custodial relation to the client(s), and am authorized to sign this release on the client's/child's behalf.

Maryland
DEPARTMENT OF HEALTH

Center for Immunization
Maryland Immunization Information System (ImmuNet)

☐ By checking this box, I authorized the Maryland Department of Health to update the client demographic information in ImmuNet if needed.

Parents/Guardians: Each time your child gets vaccinated, ask your child's provider to update/confirm the parent/guardian information in their system to send to ImmuNet.

_____ _____

Date Completed Requestor's Signature

If requesting records for more than one client, add information below. Clients 18 years and older must request their own records (i.e. fill out their own form).

1.

_____

Client First Name Client Middle Name Client Last Name

_____ _____ _____

Client Date of Birth Client Sex Client Previous Name(s)

2.

_____

Client First Name Client Middle Name Client Last Name

_____ _____ _____

Client Date of Birth Client Sex Client Previous Name(s)

3.

_____

Client First Name Client Middle Name Client Last Name

_____ _____ _____

Client Date of Birth Client Sex Client Previous Name(s)

If you wish to keep a completed copy of your form, please make a copy before submitting the form.

Mail or Fax to

Maryland Department of Health
Center for Immunization - ImmuNet
201 West Preston Street 3rd Floor, Baltimore, MD 21201
Fax: (410) 333-5893

Please mail or fax the completed form. Do not email the completed form as it places you at risk for exposing your sensitive information. E-mailed forms will not be accepted unless you are able to use an encrypted e-mail service. It is preferred if you can fill out the online form at health.maryland.gov/immunet

Once received, your request will be processed as quickly as possible. Please allow up to 21 business days (or longer), depending on the volume of requests.

MDH (For Official Use Only)

Date Received: _____ Initials: _____
Date Fulfilled: _____ Record Status: _____