

**Authorization to Release Information about Medical Records**

Name of Hospital and/or Clinic \_\_\_\_\_

Contact information for your Physician:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Your Name: \_\_\_\_\_  
Last First Middle Initial

Your Date of Birth: \_\_\_\_\_  
Day/month/year

Your Address: \_\_\_\_\_

Your Telephone #: \_\_\_\_\_

Your Social Security Number\*: \_\_\_\_\_

(\*Your child's social security number will be used only for the purposes of getting information from insurance claims, medical records, and databases that are available to the public. It will not be used for any other purposes and will be kept confidential).

Name of Organization Authorized to Receive Information:

Clinical Immunization Safety Assessment Centers

I authorize the clinic/hospital and the physician listed above to release the information specified below to BUMC and Clinical Immunization Safety Assessment Center(CISA). I specifically authorize the release of the following: Insurance claims data and medical records including charts, x-rays, and laboratory work about illnesses my child may have had during the period from birth unit until present.

I give my permission for this information to be used for the purposes of CISA adverse event consultation. I do not give permission for any other use or further disclosure of this information.

I agree that this authorization is valid for 36 months from the date I have signed this agreement. A photocopy or facsimile of this authorization is approved as the original. I understand that I may revoke this authorization at any time by contacting CISA staff.

You will receive a signed copy of this authorization form.

\_\_\_\_\_  
Signature of Patient Date

\_\_\_\_\_  
Signature of Person Conducting Interview Date