



# Immunization Record Request Application

Please print clearly.

## Applicant's Information (information for the person whose records you are requesting)

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Last Name \_\_\_\_\_

Sex Assigned at Birth    Male    Female    Born in NYC?    Yes    No

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth (month/day/year)    Medicaid Number (if applicable)

\_\_\_\_-\_\_\_\_-\_\_\_\_    \_\_\_\_\_-\_\_\_\_-\_\_\_\_

Phone Number \_\_\_\_\_ Fax (if you are requesting the record by fax) \_\_\_\_\_

Address \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Name of Hospital Where Applicant Was Born \_\_\_\_\_

Health Care Provider's Name \_\_\_\_\_

Health Care Provider's Phone Number \_\_\_\_\_

## Information of Applicant's Mother

Mother's First Name \_\_\_\_\_ Mother's Maiden Name \_\_\_\_\_  
(last name before first marriage)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mother's Date of Birth (month/day/year)

## Parent Information (If applicant is a minor, select your relationship to the child.)

Mother    Father    Guardian    Other (describe)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Email Address \_\_\_\_\_ Primary Language (if not English) \_\_\_\_\_

This is to certify that I am the parent, guardian, or other person in custodial relation to the child whose information is listed above for the immunization record search, and as such, I am authorized to view the information; or I am the individual to whom the record relates. I understand that submitting false, untrue or misleading information to the Department of Health and Mental Hygiene is a violation of New York City Health Code §3.19. I further understand that each incident of such violation is punishable by civil penalties up to \$2,000 pursuant to New York City Health Code §3.11.

**Signature of Applicant or Parent** (if the applicant is a minor)    **Date**

For more info, or to request a print copy of this form, call 311, visit [nyc.gov/health/cir](http://nyc.gov/health/cir) or email [cir@health.nyc.gov](mailto:cir@health.nyc.gov).

### Instructions to request a record by mail or fax:

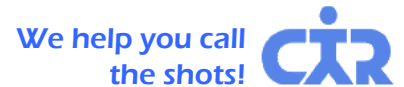
1. Complete the application.
2. Attach a copy of a valid photo ID, such as an IDNYC card, driver's license or passport.
3. Mail the completed application and the copy of ID to:

NYC DOHMH  
Citywide Immunization Registry  
42-09 28<sup>th</sup> Street, 5<sup>th</sup> Fl., CN 21  
LIC, NY 11101-4132

Or fax it to 347-396-8840.

Please do not email this application.

You will receive a response within ten business days if you submitted the application by mail, or within two business days if you submitted the application by fax.



### For Official Use Only

Form Received on \_\_\_\_/\_\_\_\_/\_\_\_\_

Status of Request:

Record Sent on \_\_\_\_/\_\_\_\_/\_\_\_\_

Record Not Found

Record Found, No Vaccines

Form Incomplete

Staff Initials: \_\_\_\_\_