



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 or email cir@health.nyc.gov.

Instructions to request a record by mail or fax:

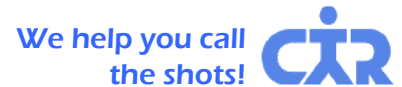
1. Complete the application.
2. Attach a copy of a valid photo ID, such as an IDNYC card, driver's license or passport.
3. Mail the completed application and the copy of ID to:

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

Or fax it to 347-396-2559.

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: _____