Utah Department of Health
USIIS Program
Phone: (801) 538-9450 Fax: (801) 538-9440
E mail: immunize@utah.gov

PROVIDER IMMUNIZATION RECORD REQUEST

Please allow 2-4 business days to process

Please fill out the information below, sign, date, and submit it to the Utah Department of Health, contact information is provided in the upper right corner of this form. **All of the below sections must be completed for approval** (incomplete forms will not be processed).

Note: not all healthcare providers in Utah participate in the Utah Statewide Immunization Information System (USIIS). Therefore, a record may not be in USIIS or the record may not be complete.

Requestor Information

Requestor Name: _____ Requestor Title: _____

Requestor Phone Number: _____ Requestor E mail: _____

Requestor Organization: _____

Requestor Organization Address: _____
Street City State Zip

Purpose of Disclosure

❑ Continuity of Care ❑ Child Caring Facilities ❑ Other: _____

Patient Information

1. Name: _____
Last First Middle
Date of birth: _____ Mother's Maiden Name: _____
2. Name: _____
Last First Middle
Date of birth: _____ Mother's Maiden Name: _____

Any other name used in the past: ❑ Maiden or Last Name ❑ First Name

Name: _____

Please indicate how you would like to receive the record(s).

(Please choose one method. Only one copy will be supplied for each individual.)

❑ E mail record(s) to: _____ ❑ Fax record(s) to: _____

❑ Mail record(s) to: _____
Street City State Zip

Important If you request the record(s) to be emailed, record(s) will be sent through secure encrypted email.

Requestor Signature

Registry information is confidential and will not be released without a signature of an authorized Physician and/or facility Director.

_____ _____ _____
Physician/Director Name (print) Physician/Director Signature Date

Dept. use only. *Date:* *Initials:*
Rev: 05/20