



Montana Immunization Information System Authorization to Release

To obtain your immunization record, first check with your health care provider or your local/tribal health department. If they are unable to provide you with your immunization history, or you are unable to access these organizations, you may complete this form.

INCOMPLETE AUTHORIZATION FORMS WILL NOT BE PROCESSED

Please allow 3 business days for processing

MAIL TO: Montana DPHHS Immunization Program
P.O. Box 202951
Helena, MT 59620 – 2951

FAX TO: (406) 444-2920
EMAIL: hhsphsiis@mt.gov

Section I Patient Information

Patient Name: _____

Last

First

Middle

Other Name(s) Used (Maiden or previous married name): _____

Date of Birth: ____/____/____

Male

Female

No longer a Montana resident

Address: _____

Street

City

State

Zip Code

Section II Receiving Organization Information (Where to send the official immunization record)

Person or Organization to Receive Immunization Record: _____

Phone Number: (____) _____

Fax Number: (____) _____

Mailing Address: _____

Street

City

State

Zip Code

Immunizations Should be Sent To the Listed: Fax Address

Note: we are unable to email records

Section III Requestor Information

Requestor Name: _____

Last

First

Middle

Phone Number: (____) _____

Relationship to the Patient _____

Reason for Request: _____

Address: _____

Street

City

State

Zip Code

I request and authorize the Montana Immunization Program to release this patient's immunization record from Montana's Immunization Information System (IIS), *imMTrax*, to the person or agency above. I declare the information above is correct and that I am authorized to sign this release on the patient's behalf. I understand that the requested information will be faxed or mailed to the designated number or address listed above.

Signed On: ____/____/____

Signature of Patient (or Parent, Legal Guardian or Managing Conservator for a Child). **Electronic or electronically generated signatures are not accepted.**

Section IV For Official Use Only

Date Searched/Released: ____/____/____

By: _____

Records Released

Record Not Found

Record Found But No Immunizations Reported

Notice: Records requests expire 30 days after the date the requestor authorized and signed the release form. One authorization form per immunization records request. Future requests will require a new records release form.