GOVERNMENT OF GUAM

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES

DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT

AUTHORIZATION TO RELEASE INFORMATION

Full Name (please print):	**Date of Birth:**
Mailing or Home Address: **City:** **State:** **Zip:**	**Ethnicity:** ☐ CHamoru ☐ Filipino ☐ Chuukese ☐ Pohnpeian ☐ Palauan ☐ Korean ☐ Japanese ☐ Caucasian ☐ Other: _____
Contact Number(s): (H): (W): (Cell):	**Place of Birth:**
Insurance Name:	**Gender:** ☐ Male ☐ Female

*Information to be disclosed: Date(s) of Service: _____ ☐ Immunization ☐ TB Skin Test (PPD) **GuWebIZ ID#**_____	**DOCUMENTS PROVIDED** ☐ Photo ID Card ☐ Birth Certificate ☐ Letter of Authorization ☐ Letter of Guardianship ☐ Power of Attorney ☐ Other: Request: ☐ Yellow shot card ☐ Official Record for S.S. Office ☐ COVID card ☐ Official Record for Travel

I hereby **authorize** and request you to release my immunization record **FROM (PLEASE CHECK ALL THAT APPLY):**

☐ Department of Public Health & Social Services Immunization Program 155 Hesler Place Hagatna, GU 96910 Phone: 671-735-7143 Fax: 671-734-1475	☐ **(Name of Physician, Hospital, Clinic, School, or Other)** **(Street Address)** **(City / State / Zip)** **(Office/Fax Number)** **(Email Address)**

TO (PLEASE CHECK ALL THAT APPLY):

☐ **(Name of Recipient)** **(Street Address)** **(City / State / Zip)** **(Contact/Fax Number)** **(Email Address)**	☐ Department of Public Health & Social Services Immunization Program 155 Hesler Place Hagatna, GU 96910 Phone: (671) 735-7143 Fax: (671) 734-1475 Email:_____

Restrictions: I understand the risk of sending information electronically via unencrypted email or fax and that 1) DPHSS is not responsible for the email or fax once in transit; and 2) the information released may be subject to re-disclosure by the recipient and may no longer be protected. _____ **(Initials)**

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or obtain a copy of any information to be used and /or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has already taken action in reliance upon this authorization.

Signature: _____ **Date:** _____

(Patient, Parent or Legal Guardian)

Please indicate relation to above recipient name, if a minor: _____

Witness (Office use only): _____ **EPI Record Search Performed: YES** ☐ **NO** ☐

Note(s):_____

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