Authorization for Disclosure of Immunization Records

CLIENT IDENTIFICATION

Name: _____ Date of Birth: _____ Maiden Name: _____

Parents/Guardians Full Names: _____

Current Address: _____

Telephone Number: _____ MCP Number: _____

The undersigned requests copies of immunization record(s) be provided by: ☐ Pick up at JPMRHC ☐ Mail to self

☐ Mail to other/E-Mail, please specify address _____

Please indicate the location of immunization records that you wish to access by ticking all that apply:

Public Health program clinics:

- ☐ A. M. Guy Memorial Health Centre
- ☐ Amelia Joe Community Centre
- ☐ Baie Verte Peninsula Health Centre
- ☐ Bell Place Community Health Centre
- ☐ Belleoram Community Health Centre
- ☐ Centreville Community Health Centre
- ☐ Change Islands Community Health Centre
- ☐ Connaigre Peninsula Health Centre
- ☐ Dr. Brian Adams Memorial Community Health Centre
- ☐ Dr. C.V. Smith Memorial Community Health Centre
- ☐ Dr. Y.K. Jeon Kittiwake Health Centre
- ☐ Exploits Community Health Centre
- ☐ Fogo Island Health Centre
- ☐ Grand Falls-Windsor Community Health Centre
- ☐ Green Bay Community Health Centre (CNA building)
- ☐ Lewisporte Community Health Centre
- ☐ Musgrave Harbour Community Health Centre
- ☐ New World Island Community Health Centre
- ☐ Notre Dame Bay Memorial Health Centre
- ☐ Robert's Arm Community Health Centre
- ☐ St. Alban's Community Health Centre
- ☐ St. Brendan's Community Health Centre

Immunization Records at Central Health Emergency Depts:

- ☐ Central Newfoundland Regional Health Centre
- ☐ Dr. Hugh Twomey Health Centre
- ☐ Green Bay Health Centre
- ☐ James Paton Memorial Regional Health Centre
- ☐ Lewisporte Health Centre

Other Central Health Services:

- ☐ Employee Wellness, Health and Safety Department at Central Health
- ☐ Other Central Health location –please specify: _____

_____ _____

Signature of Client / Authorized Representative **Date**

If the person signing is not the client, state the relationship or authority to do so: _____

(Relationship / Authority)

Please send the completed and signed form to:

Disclosure- Immunization Records
Health Protection Division, Level 1
James Paton Memorial Regional Health Centre
125 TransCanada Highway
Gander, NL A1V 1P7
Telephone: (709) 651-6238 Fax: (709) 651-6483
Email: immunizations@centralhealth.nl.ca

1. Central Health acknowledges and respects the privacy of individuals. Personal health information is disclosed in accordance with the *Personal Health Information Act, SNL2008 cP-7.01*. The information collected on this form will be used for processing your request for disclosure of personal health information.
2. The authorization must contain a valid signature of the client or representative (as defined by section 7 of the *Personal Health Information Act, SNL2008 cP-7.01*.
3. The authorization must be submitted to Central Health within 60 days of dated signature. The authorization may be revoked in writing at any time, except where disclosure has occurred based on the current signed authorization.
4. As required, copies of supporting documents may be requested to support authorized disclosure of personal health information.