Montana Immunization Information System
Authorization to Release Form

To obtain a copy of your immunization record, **first check with your healthcare 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 request records from our office using the below 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: _____
First Middle Last

Previous Legal Name(s) Used (if different than above): _____

Date of Birth: ____/____/____ ☐ Male ☐ Female ☐ *No longer a Montana resident*

Address: _____
Street City State Zip Code

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

☐ Please mail my/child's records to (Person/Org to Receive): _____

Address: _____
Street City State Zip Code

☐ Please fax my/child's records to (Person/Org to Receive): _____

Fax Number: _____ ***Note: We are unable to email records**

Section III Requestor Information

Requestor: _____
First Middle Last

Contact Phone Number: ( ) _____ Relationship to Patient _____

Reason for Request: ☐ **Continuing Care** ☐ **Child Care** ☐ **Employment** ☐ **School** ☐ **Travel** ☐ **MMR Record** ☐ **Personal Records**

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.

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

Section IV For Official Use Only

Date Searched/Released: ____/____/____ By: _____

☐ Records Released ☐ Patient Record Not Found ☐ Specific Record Requested 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.

Revised 04/2025