BLUE VALLEY community Action PARTNERSHIP

Helping People. Changing Lives.

AUTHORIZED INFORMATION RELEASE FORM

By signing this, I specifically authorize Blue Valley Community Action Partnership Immunization Program to use/and or disclose protected health information (PHI)

Patient's Name:_____ DOB:_____

Patient's Name:_____ DOB:_____

Patient's Name:_____ DOB:_____

Patients Address:_____

Patient's Phone:_____

What immunizations records are you requesting?

- ☐ Any/All immunizations on file
- ☐ History of varicella/date contracted ____/____/____
- ☐ COVID-19 Only

Release Information To:

Blue Valley Community Action Partnership
Immunization Program
1122 Main Street
Crete, NE 68333
Phone: (402)826-2141
Fax: (402)381-0057
email: jvyhnalek@bvca.net

Authorized Information Released From:

Clinic:_____

Address:_____

Phone:_____

Fax: _____

Signature: _____Date:___/___/____ Phone: _____