Immunization Record Request Application

Please print clearly.

Applicant's Information (information for the person whose records you are requesting)

First Name | Middle Name

Last Name

Sex Assigned at Birth Male Female | Born in NYC? Yes No

/ /

Date of Birth (month/day/year) | Medicaid Number (if applicable)

- - | - -

Phone Number | Fax (if you are requesting the record by fax)

Address | Apt.

City | State | ZIP Code

Name of Hospital Where Applicant Was Born

Health Care Provider's Name

Health Care Provider's Phone Number

Information of Applicant's Mother

Mother's First Name | Mother's Maiden Name (last name before first marriage)

/ /

Mother's Date of Birth (month/day/year)

Parent Information (If applicant is a minor, select your relationship to the child.)

Mother Father Guardian Other (describe)

First Name | Last Name

Email Address | Primary Language (if not English)

This is to certify that I am the parent, guardian, or other person in custodial relation to the child whose information is listed above for the immunization record search, and as such, I am authorized to view the information; or I am the individual to whom the record relates. I understand that submitting false, untrue or misleading information to the Department of Health and Mental Hygiene is a violation of New York City Health Code §3.19. I further understand that each incident of such violation is punishable by civil penalties up to $2,000 pursuant to New York City Health Code §3.11.

Signature of Applicant or Parent (if the applicant is a minor) **Date**

Instructions to request a record by mail or fax:

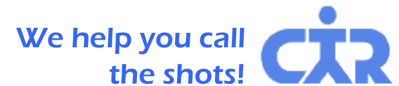
1. Complete the application.
2. Attach a copy of a valid photo ID, such as an IDNYC card, driver's license or passport.
3. Mail the completed application and the copy of ID to:

NYC DOHMH
Citywide Immunization Registry
42-09 28th Street, 5th Fl., CN 21
LIC, NY 11101-4132

Or fax it to 347-396-8840.

Please do not email this application.

You will receive a response within ten business days if you submitted the application by mail, or within two business days if you submitted the application by fax.



For Official Use Only

Form Received on ___/___/____
Status of Request:
☐Record Sent on ___/___/_____
☐Record Not Found
☐Record Found, No Vaccines
☐Form Incomplete
Staff Initials: ________________

For more info, or to request a print copy of this form, call 311, visit **nyc.gov/health/cir** or email **cir@health.nyc.gov**.