NYC Health
www.nyc.gov/health/cir

Citywide Immunization Registry
We help you call the shots
cir@health.nyc.gov

Immunization Record Request Application

PLEASE PRINT CLEARLY

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

LAST NAME

FIRST NAME MIDDLE NAME

Sex assigned at birth: ☐ Male ☐ Female

DATE OF BIRTH: ☐☐/☐☐/☐☐☐☐ (month / day / year)

MEDICAID NUMBER (if applicable): ☐☐☐☐☐☐☐☐

STREET ADDRESS APT #

CITY STATE ZIP CODE

APPLICANT'S PHONE: ☐☐☐-☐☐☐-☐☐☐☐

FAX TO: ☐☐☐-☐☐☐-☐☐☐☐ (Enter fax number if you are requesting the record by fax.)

NAME OF HOSPITAL WHERE APPLICANT WAS BORN

NAME OF HEALTH CARE PROVIDER

PROVIDER'S PHONE NUMBER: ☐☐☐-☐☐☐-☐☐☐☐

Information of Applicant's Mother:

MAIDEN NAME (Last name prior to first marriage) FIRST NAME

MOTHER'S DATE OF BIRTH: ☐☐/☐☐/☐☐☐☐ (month / day / year)

Parent Information (if applicant is a minor)

Relationship to Child: ☐ Mother ☐ Father ☐ Guardian ☐ Other _____ (please describe, e.g. grandparent)

LAST NAME FIRST NAME

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 **Date**

To Request an Immunization Record by Mail or Fax:

(1) Complete the **Immunization Record Request Application**.
(2) Attach a clear copy of a valid photo ID, such as a driver's license or passport.
(3) Mail or fax both the completed application and copy of ID.

MAIL:
NYC Dept. of Health and Mental Hygiene - Citywide Immunization Registry
42-09 28th Street, 5th Fl.,CN 21
Long Island City, NY 11101-4132

FAX: 347-396-2559

Do not email this form.

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

Call **311** if you have any questions or concerns, or to request a print copy of this form.

For Official Use Only:
Date Form Received: ___/___/____
Status of Request
__ Record Sent ___/___/___
__ Record Not Found
__ Record Found, no imm.
__ Form Incomplete
Staff Initials: _____