ADHS

Immunization Record Request Form

All immunization record requests must be accompanied by documents that identify the person requesting the immunization record. Examples of acceptable forms of identification are a state-issued photo driver's license with address, a state-issued photo identification card with address or a U.S. passport or passport card with photo. **Please lighten the copy of the identification cards.**

If the record requested is for a minor under 18 years of age, please state your relationship to the minor in the "Requestor's Relationship" field.

Immunization record requests will be processed within 5-7 business days.
***Due to an increase in immunization records requests, please anticipate delays.**

To potentially access your records faster, please try using MyIR Mobile to find your record before submitting an Immunization Record Request form. Follow this link to sign up for MyIR Mobile https://myirmobile.com/

What immunization records are you requesting?

- ○ Any/All immunizations on file with the Arizona Department of Health Services
- ○ Childhood vaccinations/for a minor child
- ○ COVID-19 Only (Please submit copy of verification of vaccination such as COVID-19 vaccination card, ADHS COVID-19 verification email, if available)

Estimated date of first COVID-19 vaccination | Location of COVID-19 vaccination | State/Country

Estimated date of second COVID-19 vaccination | Location of COVID-19 vaccination | State/Country

Scroll down or click Here to fill out Immunization Record Request Form.

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IMMUNIZATION RECORD REQUESTED FOR:			
First Name:	Middle Name:	Last Name:	
Date of Birth: Month / Day / Year	Gender: ☐ Male ☐ Female	Phone Number: ( ) -	
Current address:	City:	State:	Zip:

REQUESTOR'S INFORMATION (PERSON REQUESTING RECORD)			
Requestor's Name:	Requestor's Relationship:		
Current address:	City:	State:	Zip:
Phone: ( ) -	E-mail:		

By signing this agreement, I _____ (print name of requestor) hereby authorize the Arizona Department of Health Services (ADHS) to release immunization information that may be held by the Arizona State Immunization Information System of the Arizona Department of Health Services. This information is to be released and sent to the following:

☐ Doctor's office/Health Care Provider ☐ School ☐ Daycare/Childcare center ☐ Self (Records will be sent to you only if it is your record)

Recipient/To the Attention of:	Name of Organization:
☐ Fax record to fax number:	Phone number: ( ) -
☐ Email record to email address:	

Requestor's Signature: Date: /

Once this form is completed, please print, sign and date. Send form along with supporting documents to ASIIS via Email, Fax or Mail.

Email: ASIISHelpDesk@azdhs.gov
Fax: 602-364-3285 ATTN: ASIIS Records Request
Mail: Arizona Department of Health Services/Immunization Program-ASIIS
150 North 18th Ave., Suite 120
Phoenix, AZ 85007

If your records are found in our system we will send the records to the destination you requested above. If your records are not found in our system, we will contact you.