



## Requests for Immunization Records Ohio Impact Statewide Immunization Information System (ImpactSIIS)

The Ohio Department of Health maintains the Ohio Impact Statewide Immunization Information System (ImpactSIIS), an online tool that allows providers to record immunizations/vaccinations administered in the state of Ohio. If you are seeking to obtain a copy of your immunization records from the state system, it is important to know that such records are protected by medical confidentiality laws and that there may be a number of other ways to access them.

If you need vaccination records, you can:

- Ask your healthcare provider, who will have a copy of your medical records and may be able to access the state system.
- Contact your local health department, which may be able to access the state system. To find your health department, go to [odh.ohio.gov/local](http://odh.ohio.gov/local).
- Ask a workplace, camp, or school that you may have provided the records to in the past.

If you choose to request vaccination records from the Ohio Department of Health:

- Staff cannot verify whether your records are in the state's ImpactSIIS system through a phone or email request.
- You must **mail**:
  - The [ODH Authorization to Release form](#) with your original signature. A copy, fax, or email will not be accepted.  
Please make sure you indicate your current mailing address on the Authorization to Release form.
  - A photocopy of a government-issued ID with your signature, to be compared to the signature on the form.  
Please note: An Authorization to Release form is only good for one request. If you are requesting information for a spouse or a dependent, you will need to fill out a second form and provide supporting ID information for that individual.
- Mail both items to:  
Immunization Program  
Ohio Department of Health  
246 N. High St.  
Columbus, OH 43215
- The paperwork **cannot be emailed or faxed.**
- COVID-19 vaccine providers in Ohio are required to report patient information into the ImpactSIIS system when the COVID-19 vaccine is administered. If you have received the COVID-19 vaccine in Ohio, your information should be in the system.
- It is important to note that medical providers in Ohio are not required to report other immunizations to the state system. It is possible that other vaccinations will not be recorded in our system.



Authorization to Disclose Health Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the Ohio Department of Health to (Client, Patient or Personal Representative) disclose specific and identifiable health information from the records of the above-named person to (Recipient Name/Address/Phone/Fax):

\_\_\_\_\_

for the specific purpose(s) of:

\_\_\_\_\_

Specific information to be disclosed:

\_\_\_\_\_

This authorization will expire on the following date, event or condition:

\_\_\_\_\_

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time. I further understand that any action taken by the Ohio Department of Health in accordance to this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information unless otherwise provided for by state or federal law.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

\_\_\_\_\_  
(Signature of Client/Patient) (Date) (Witness-If Required)

\_\_\_\_\_  
(Signature of Personal Representative) (Date) (Relationship/Authority)

\*\*\*\*\*

NOTE: This Authorization was revoked on: \_\_\_\_\_  
(Date) (Signature of Staff)