If you are requesting a copy of your immunization record, please complete the following steps:

1) Scroll down to find the:  
   *Release of Information, Immunization Record Authorization* form
2) Print out the form
3) **PRINT** your information, completing all areas
4) Sign and date form
5) Send to appropriate address/fax/e-mail located at bottom of form

Requests for immunizations will only be processed from September 15th through April 15th during normal university hours.
University of Pittsburgh at Johnstown  
Office of Health & Counseling Services  
Release of Information, Immunization Record Authorization  
Please PRINT

Student/Client Name: _________________________  
Student ID#: ____________  

Month and Year of Graduation: ________________  
OR  
Date of Birth: ____________  

Last Date of Attendance: ________________  

I, _____________________________________ hereby authorize the University of Pittsburgh at Johnstown,  
Office of Health and Counseling Services to release my immunization record to:

- NAME: ________________________________________  
- ADDRESS: _____________________________________  
  ______________________________________  
- E-MAIL: _______________________________________
- PHONE: _______________________________________  

FORM IN WHICH INFORMATION SHOULD BE RELEASED: (Check one box ONLY)

☐ Scanned and sent to your e-mail address  
☐ U.S. Postal Mail

These records are required for the specific purpose of:

☐ Providing care/Treatment planning  
☐ Other (specify) ____________________________________
  
☐ I designate this release is in effect for a limited number of days____ (do not exceed 364 days)  
☐ I have read and fully understand the above statements as they apply to me. I consent to release of records and/or  
  information to the purpose(s) as stated above.

________________________  __________________________
Patient/Client Signature                  Date                  Witness                      Date

________________________  __________________________
Parent/Legal Representative Signature    Date                  Relationship to Patient/Client

A copy of this Authorization shall be deemed valid as original. This Authorization must be signed and dated.

University of Pittsburgh at Johnstown  
Office of Health & Counseling Services  
450 Schoolhouse Rd. Johnstown, PA 15904

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