Federal Code 45 CFR 164.524(b)(2) mandates that a Covered Entity furnishes medical records no later than 30 calendar days from receiving the individual's request. If a covered entity is unable to provide access within 30 calendar days, the covered entity may extend the time by no more than an additional 30 days. To extend the time, the covered entity must, within the initial 30 days, inform the individual in writing of the reasons for the delay and the date by which the covered entity will provide access. Only one extension is permitted per access request.

UNIFIED GOVERNMENT PUBLIC HEALTH DEPARTMENT OF WYANDOTTE COUNTY
619 Ann Avenue, Kansas City, KS 66101
Phone: (913) 573-8855 Fax: (913) 573-6755
COVID VACCINE REPLACEMENT CARD FORM

I, _____, (Patient Name & Date of Birth) authorize to share the following specific information with:

☐ **Release to:**	Name: Unified Government Public Health Department of Wyandotte County Address: 619 Ann Ave, Kansas City KS 66101 Phone Number: (913) 573-8855 Email address:

What info about me will be shared: *COVID Vaccine Card(s)*	Date of Service o When was the COVID Vaccine (s) received: _____ Location of Service o Where was the COVID Vaccine (s) received: _____ _____

A health department staff will contact patient or guardian when ready for pick up, within 7 business days)
The information may be shared:

☐ in person (will pick up) *picture I.D. required at the time of pick up.*

Provide phone number:_____

☐ by email **I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.*

☐ **I understand:**

- That there is a risk that a limited release of information can potentially open up access by others to all my confidential information.
- That this release is limited to and valid for what I write above upon release. If I would like to release information about me in the future, I will need to sign another written release.
- That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from this agency.
- That this agency and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing. This authorization will expire upon release.

Patient or Parent/Guardian signature: **Date:**

HEALTH DEPT EMPLOYEE INTAKE:_____ **Released by:**_____ **Date:**_____

Reaffirmation and Extension (if additional time is necessary to meet the purpose of this release)
I confirm that this release is still valid, and I would like to extend the release until _____
New Date
Signed:_____ **Date:**_____