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

Records are kept for seven years from your date of separation from the University.

Requests for immunizations will only be processed from September 15th through April 15th during normal university hours.
Student Name: _________________________                                Student ID#: _____________

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

OR

Last Date of Attendance: ______________________

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

• STUDENT NAME: ________________________________________

• ADDRESS: _____________________________________

• E-MAIL: _______________________________________

• PHONE: _______________________________________

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

☐ Scanned and sent to your e-mail address    OR    ☐ Student’s U.S. Postal Mail Address

________________________  ____________________________
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 for a period of one year from date of signature.
This Authorization must be signed and dated.
Records are kept for seven years from your date of separation from the University.

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

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