Patient Name_____Date of Birth _____

Please complete and sign this form so that we can transmit you or your child's immunization information to the Colorado Immunization Information Registry, by signing this form you grant us permission to transmit you or your child's immunization information to the Colorado Immunization Registry. You will only have to supply this information once per patient.

Mother's first, middle and last name	
Mother's maiden name	
Father's first, middle and last name	
Are you a self-pay or have Medicaid Insurance?	Yes No Yes No
Birthing facility name, address and zip code	
Birthing facility city	
Is the patient part of a multiple birth?	
Birth order (if a multiple)	

Information supplied by _____ Relationship to Patient _____

Signature_____Date _____