# OFFICE OF REFUGEE RESETTLEMENT
## Division of Children's Services
## AUTHORIZATION FOR RELEASE OF RECORDS

Please complete this form, and attach any required documentation (see Box II and III for what type of documentation will be required from you or your organization).

**THIS VERSION IS FOR REQUESTS OF VACCINATION RECORDS ONLY**

Fax this form and attachments to (210) 208-5204, or email it to information@orrncc.com.

**I. Subject of record request.**

**Subject of Record Request's Name[1]:** N/A

**UAC Name[2]:** _____ **UAC Alias:** _____

**UAC Alien #:** _____ **Is the UAC currently in ORR custody?** ☐ Yes ☒ No

**UAC Date of Birth:** _____ **UAC Age:** N/A

**Address (if UAC is currently in ORR custody name care provider):**

N/A

**II. Reason for request.** *(Please check the boxes that apply and attach any required documents.)*

**I am requesting records for the purpose of:**

☐ Representing the UAC in immigration court.

☒ Other: Providing medical care

**Type of request.**

☐ This is a standard request.

☒ This is an URGENT request because:

☐ UAC has a court date within 30 days and I have attached a Notice of Hearing or other document confirming the court date.

☐ UAC is turning 18 years old in less than 30 days.

☒ Other[3]: Patient is being seen in the office/ need to determine which vaccinations to administer

[1] This is the person whose records you are requesting, usually an unaccompanied alien child (UAC) or a sponsor/potential sponsor of the UAC.

[2] ORR maintains its records by UAC name. If the record request is for a sponsor or potential sponsor, please name the UAC to which the sponsor/potential sponsor's information would be connected.

[3] Requests marked urgent for reasons other than those listed above are subject to approval by the ORR/DCS Division Director after consideration of exigent circumstances.

**III. Requesting party.** *(The requesting party is usually an attorney, BIA accredited representative, or government official. Please check the box that applies and attach any required documentation).*

**Name of requesting party:** (provider's name)

**Name of requesting party's organization:** (name of clinic)

**Requesting party's mailing address[4]:** (mailing address, phone number and fax number)

(1) ☐ I am an attorney or BIA accredited representative representing the subject of the record request before an immigration court or the U.S. Department of Homeland Security and I have attached a signed G-28; EOIR-27; or EOIR-28.

(2) ☐ I am an attorney not representing the subject of the record request before an immigration court or the U.S. Department of Homeland Security and I have attached a) a statement on my office's official letterhead verifying that I am the legal representative of the subject of the record request and signed by the subject of the record request; or b) a court document (e.g. Notice of Appearance) verifying that I am the legal representative of the subject of the record request.

(3) ☐ I am an ORR-funded Legal Service Provider, pro bono attorney, or volunteer attorney or staff person, receiving Federal funding pursuant to a contract or sub-contract with ORR. The subject of the request is a UAC currently in the custody of ORR, or formerly in the custody of ORR for which I am receiving post-release legal service funding through a contract or sub-contract with ORR.

(4) ☐ I am a representative of a non-U.S. Department of Health and Human Services/Administration for Children and Families government agency.

(5) ☒ Other: Medical provider

**IV. Checklist Request.** *(Please enter the name of your organization and staff names and check the boxes for the type of records you are requesting.)*

You are hereby authorized and requested to disclose and give copies to **the healthcare clinic** or any of its duly authorized representatives, including **healthcare staff** any and all records and information concerning the undersigned which you may have in your possession, including but not limited to the following categories of information:

| | |
|---|---|
| ☐ Placement and Transfer | ☐ Psychological/Psychiatric |
| ☐ Release/Discharge | ☐ HIV/STD[5] |
| ☐ Case Management | ☐ Substance Abuse Treatment |
| ☐ Clinical | ☐ Juvenile Delinquency/Criminal |
| ☐ Immigration/Legal | ☐ Home Study Records[6] |
| ☐ Educational | ☐ Post-Release Service Records[6] |
| ☐ Contacts/Communication | ☐ General Information |
| ☐ Medical | ☒ Other: **Vaccination records** |

[4] ORR UAC Program uses express delivery services to fulfill records requests. Therefore the address provided must be a street address, not a post office box.

[5] Requests for HIV/STD records may only be authorized by the UAC, or the parent or legal guardian of a UAC if the UAC is under the age of 14.

[6] Home study and post-release service records will not be released without the signature of sponsor/potential sponsor to whom those records pertain.

**V. Signatures.** *(Not required for requests from government agencies, see Box II item (4)).*

**I UNDERSTAND THAT THIS INFORMATION CANNOT BE DISCLOSED WITHOUT MY AUTHORIZATION AND THE LAW REQUIRES THIS NOTICE. I FURTHER UNDERSTAND THAT THIS CONSENT EXPIRES ONE YEAR FROM THE DATE OF MY SIGNING (OR CARE GIVERS) AND I MAY WITHDRAW MY CONSENT AT ANY TIME.**

**Authorizing Signature[7]:** _____ **Date:** _____

**(if patient is over 14 yrs, patient should sign, if under 14, parent, guardian or sponsor signs) LHDs are recommended to get client signature.**

**Print Name:** _____

**Address:** _____

**Phone Number:** _____ **Relation to UAC:** _____

**Witness' Signature:** _____ **Date:** _____

**Print Name:** **(Healthcare provider or clinic staff can sign)**

**Relation to UAC:** _____

[7] If the UAC under the age of 14 an individual with care-giving authority (parent, legal guardian, or sponsor) must sign on the UAC's behalf and their name, address, phone number and relation to the UAC must be printed below the signature.