



**ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
PUBLIC HEALTH DEPARTMENT**

Division of Communicable Disease Control and Prevention
Immunization Program
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Patient Information Request Form

Alameda County Perinatal Hepatitis B Prevention Program

Date: _____
To: _____ Fax: _____
From: _____
[Sender is exempt from requiring authorization per HIPPA [citation 164.512 (b)]]
Phone: _____ Fax: **510-268-2111**
Number of pages (including cover sheet): 1

Name of Mother

Mother's DOB

Delivery Date

Name of Child

Child's DOB

Please fax the information requested:

☐ Gender of Baby: ☐ Male ☐ Female Name, if known: _____
Date of Birth: _____ Time of Birth: _____
Date of HBIG Injection: _____ Time of HBIG Injection: _____
Date of HBV Vaccine #1: _____ Time of HBV Vaccine #1: _____
(PEP report will be made if any information missed in above area)

☐ Hepatitis B vaccine series dates given:
#1: _____ #2: _____ #3: _____ #4: _____

☐ Post-vaccination Serology Record: (Please attach/fax lab results)
HBsAG test date: _____ Test result: _____
Anti-HBs test date: _____ Test result: _____

☐ HBsAG positive report
☐ Update address: _____ Phone number: _____
☐ Next appointment: _____ or no longer seen in your office since _____
☐ Pediatrician name: _____ Phone: _____ Fax: _____
☐ Other: _____
☐ Name of person completing above information: _____

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Note: Privacy Rule (HIPPA) permits covered entities to disclose PHI without authorization to public health authorities or other entities who are legally authorized to receive such reports for the purpose of preventing or controlling disease. This includes the reporting of disease, conducting public surveillance, investigations, or interventions.