Decline or Start Sharing/Information Request Form

PLEASE CHECK (√) THE STATEMENT(S) BELOW THAT APPLY:	
MY FULL NAME:	**RELATIONSHIP TO PATIENT** ☐ self ☐ parent/guardian
Name of Patient:	Patient's Address:
Patient's Date of Birth:	City/Zip Code:
	Phone:

DECLINE SHARING

☐ **I DECLINE to allow my/my child's immunization record to be shared with other health care providers, agencies, or schools in the California Immunization Registry.***

** Note: The immunization record may still be recorded in the registry for use by your physician's office. By law, public health officials can also access immunization records in the case of a public health emergency.*

START SHARING (Declined earlier, now have changed mind and wish to share.)

☐ **I ALLOW my/my child's immunization record to be shared with other health care providers, agencies, or schools in the California Immunization Registry.**

REQUEST INFORMATION

☐ I REQUEST a list of agencies who have viewed my/my child's immunization registry record.

☐ I REQUEST to review or correct my/my child's immunization registry record. I understand that any changes made to this record must be verified by appropriate documentation from my health care provider.

Signature:	**Date:**

Alliance member or parent: Sign, date, and fax this form to 925-407-1300 or mail it to
California Department of Public Health
CAIR Bay Area Regional Manager
2950 Buskirk Ave. unit # 225
Walnut Creek, CA 94597