

## Decline or Start Sharing/Information Request Form

<b>PLEASE CHECK (✓) THE STATEMENT(S) BELOW THAT APPLY:</b>	
<b>MY FULL NAME:</b>	<b>RELATIONSHIP TO PATIENT</b> <input type="checkbox"/> self <input type="checkbox"/> parent/guardian
Name of Patient:	Patient's Address:
Patient's Date of Birth:	City/Zip Code:
	Phone:
<b>DECLINE SHARING</b>	
<input type="checkbox"/> <b>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.*</b>	
<i>* 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.</i>	
<b>START SHARING</b> (Declined earlier, now have changed mind and wish to share.)	
<input type="checkbox"/> <b>I ALLOW my/my child's immunization record to be shared with other health care providers, agencies, or schools in the California Immunization Registry.</b>	
<b>REQUEST INFORMATION</b>	
<input type="checkbox"/> I REQUEST a list of agencies who have viewed my/my child's immunization registry record.	
<input type="checkbox"/> 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.	
<b>Signature:</b>	<b>Date:</b>

### For office use only:

Fax this form to the California Immunization Registry at: **925 - 407-1300** (fax)