

Decline or Start Sharing/Information Request Form

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| PLEASE CHECK (✓) THE STATEMENT(S) BELOW THAT APPLY: | |
| MY FULL NAME: | RELATIONSHIP TO PATIENT <input type="checkbox"/> self <input type="checkbox"/> parent/guardian |
| Name of Patient: | Patient's Address: |
| Patient's Date of Birth: | City/Zip Code: |
| | Phone: |
| DECLINE SHARING | |
| <input type="checkbox"/> 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.* | |
| <p><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></p> | |
| START SHARING (Declined earlier, now have changed mind and wish to share.) | |
| <input type="checkbox"/> 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 | |
| <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. | |
| Signature: | Date: |
| For office use only: File this form in the patient medical record. Questions? Call SDIR: (619) 692-5656. | |