Decline or Start Sharing/ Information Request Form

KAISER MEMBERS ONLY: This signed form should be faxed or emailed back to SDIR

Fax: (619) 692-6619 Email: sdir@sdiz.org

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:
☐ **KAISER MEMBER** ☐ **OTHER PROVIDER**	Phone:

DECLINE SHARING

☐ **I DECLINE to allow my/my child's immunization record and tuberculosis (TB) test results 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 and tuberculosis (TB) test results 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 and tuberculosis (TB) test results 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:**

For office use only:
File this form in the patient medical record. Questions? Call SDIR: (619) 692-5656.