

Decline or Start Sharing/Information Request Form

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:

**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**