# Decline or Start Sharing/Information Request Form

| PLEASE CHECK (√) THE STATEMENT(S) BELOW THAT APPLY: | |
|---|---|
| **MY FULL NAME:** | **RELATIONSHIP TO PATIENT**<br>☐ 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. **[P*rovider: Please write your Provider ID:_____ and fax this form to the CAIR Help Desk: (213) 351-2784. We will process this request.]***

☐ 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:** |
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