



Regional Immunization Data Exchange



CALIFORNIA IMMUNIZATION REGISTRY – REGION IV

REFUSAL/INFORMATION REQUEST FORM

PLEASE RETURN THIS COMPLETED FORM

Mail: San Joaquin County Public Health Services Fax: (209) 462-2019 / ATTN: Immunization Registry
ATTN: Immunization Registry
P.O. Box 2009 / Stockton, CA 95201

MY FULL NAME:	RELATIONSHIP TO PATIENT:
Name of Patient:	Patient's Address:
Patient's Date of Birth:	City/Zip Code:
	Phone:

PLEASE CHECK (v) THE STATEMENT(S) BELOW THAT APPLY:

DECLINE SHARING AND/OR REMINDER NOTICES

REQUIRED:

I REFUSE to permit the patient's immunization/tuberculosis (TB) test record to be shared with other health care providers, agencies, or schools in the RIDE Immunization Registry (RIDE).*

(*By law, the immunization record/TB test may still be recorded in the system for use by your physician's office and public health officials.

OPTIONAL:

I REFUSE to allow the Registry Reminder/Recall System to notify the patient when immunizations are due.

ALLOW SHARING (DECLINED IN THE PAST)

I ALLOW the patient's immunization/tuberculosis (TB) test record to be shared with other health care providers, agencies, or schools in the RIDE Immunization Registry (RIDE).

INFORMATION REQUEST

I REQUEST a list of agencies who have accessed the patient's Immunization Registry Record.

I REQUEST to review/correct the patient's Immunization Registry Record. I understand that any changes made to this record must be verified by appropriate documentation from my Health Care Provider.

Patient/Parent/Guardian Signature:	Date:
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Please allow up to 10 business days for processing.