

CALIFORNIA IMMUNIZATION REGISTRY – REGION IV

REFUSAL/INFORMATION REQUEST FORM

PLEASE RETURN THIS COMPLETED FORM

Mail: **San Joaquin County Public Health Services** **ATTN: Immunization Registry** **P.O. Box 2009 / Stockton, CA 95201**	**Fax:** **(209) 462-2019** **Email:** **support@myhealthyfutures.org**
MY FULL NAME:	**RELATIONSHIP TO PATIENT:**
Name of Patient:	**Patient's Address:**
Patient's Date of Birth:	**City/Zip Code:**
	Phone:

PLEASE CHECK (√) 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:**

Please allow up to 10 business days for processing.