

## Maryland Immunization Information System (ImmuNet) Opt-out Form

Maryland's Immunization Information System (ImmuNet) is a secure health information system containing the names and immunization history of people who have received vaccinations in Maryland. This information is available only to authorized health care providers, child care providers, and schools. Participation in ImmuNet is voluntary and you may opt out at any time by completing this opt-out form.

You may download and print this form, or request a hard copy by contacting the ImmuNet Help Desk at [dhmh.mdimmunet@maryland.gov](mailto:dhmh.mdimmunet@maryland.gov) or 410-935-9295.

Please complete the information for the person whose immunization record should not be shared with participants of the ImmuNet program.

### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email address: \_\_\_\_\_

### Information about the person completing this form

Information about the person completing the opt-out request (this information will be used to contact you if this form is incomplete or unclear, and will be filed as legal documentation of the opt-out request).

Same as Patient Information above (if not, please provide the information below)

Relationship to patient: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email address: \_\_\_\_\_

**Signature**

By checking the box below, I understand that my request to opt-out of ImmuNet for myself, my minor child, or person for whom I am a legal guardian means that the patient's information will not be available to or shared with authorized health care providers. I understand that the Maryland Department of Health and Mental Hygiene (DHMH) and Local Health Departments (LHDs) will still have access to the patient's record. Physician or school requests for information must be accompanied by a signed medical release.

I agree:

I verify the information above is accurate and certify that I have the legal authority to make decisions for the patient listed on this form.

Signature of Person Requesting the Opt-out: \_\_\_\_\_

Date completed: \_\_\_\_\_

If you wish to keep a completed copy of your form, please make a copy before submitting the form.

**Mail or Fax to**

Maryland Department of Health and Mental Hygiene  
Center for Immunization - ImmuNet  
201 West Preston Street 3<sup>rd</sup> Floor, Baltimore, MD 21201  
Fax: (410) 333-5893