



ImmuNet Maryland's Immunization Registry

Refusal to Permit Form

Please complete this form if you do not wish your/your child's immunization record to be shared with authorized users of the **ImmuNet** program. Please print.

I _____ wish to prevent sharing of my/ my child's
Individual or Parent/Guardian (first/last name)

_____/_____/_____ M F
Child's first/middle/last name Date of Birth (month/date/year) Gender (Please Circle)

_____/_____/_____/_____ shot record with
Address City State Zip Code

ImmuNet participants.

By signing this form, I understand that my/my child's immunization information will not be shared with authorized users of **ImmuNet**. The Maryland Department of Health and Mental Hygiene and local health departments will have access to my/my child's record as will the provider who documented the shots in **ImmuNet**. All physician or school requests for information must be accompanied by a signed medical release by the individual or parent/guardian. As always, it is best to maintain a hard copy of your/your child's immunization record for reporting and verification.

Signature of Individual/Parent/Guardian

Date (month/date/year)

Please place a copy in the patient's medical chart.

Please FAX this form to:
The Center for Immunization
410-333-5893