Stanislaus County Office of Education
Tom Changnon, Superintendent

Child & Family Services

Tony Jordan, Executive Director
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Refusal/Information Request Form

PLEASE FAX THIS COMPLETED FORM
Attn: Immunization Registry 209-468-8361

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:
Please note: If you change your mind at any time, please let us know.

REFUSAL:

REQUIRED:

☐ I REFUSE to permit the patient's immunization record to be entered into the immunization Registry.

OPTIONAL:

☐ **I REFUSE to ALLOW THE Immunization Registry <u>Reminder Recall System</u> to notify me when immunizations are due.**

INFORMATION REQUEST:

☐ **I REQUEST a list of persons 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.**

☐ **I REQUEST that the Immunization Registry STOPS sharing the patient's immunization records with other Health Care Providers and remove the record from the system.**

Patient/Parent/Guardian Signature:	**Date:**