



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 mdh.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.

Client Information

First Name: _____ Middle Initial: _____ Last Name: _____

Maiden Name (if applicable): _____

Mother’s Maiden Name: _____

Date of Birth: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ E-mail 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/unclear, or if more information is needed to match the record, and will be filed as legal documentation of the opt-out request).

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

Relationship to client: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ E-mail Address: _____



Signature

- By checking this box, I declare under penalty of perjury under the laws of the state of Maryland that this information is true and correct, and that I am the client, or am authorized to make decisions for the client listed on this form.
- By checking this box, 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 client’s information will not be available to or shared with authorized health care providers. Data that has been previously shared or released cannot be retracted.
- By checking this box, I understand that the Maryland Department of Health (MDH) and Maryland’s Local Health Departments (LHDs) will still have access to the client’s record. Physician or school requests for information must be accompanied by a signed medical release.
- By checking this box, I also allow the Maryland Department of Health (MDH) to update the Client’s Information (provided above) in ImmuNet for future record matching.

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
Center for Immunization - ImmuNet
201 West Preston Street 3rd Floor, Baltimore, MD 21201
Fax: (410) 333-5893

Please mail or fax the completed form. Do not e-mail the completed form as it places you at risk for exposing your sensitive information. E-mailed forms will not be accepted unless you are able to use an encrypted email service.

Once received, your request will be processed as quickly as possible, in no more than 5 business days.

MDH (For Official Use Only):

Date Received: _____ Initials: _____
Date Fulfilled: _____ Record: Opted Out / Demographics Updated / Not Found