Release of Opted-Out Records Form

ImmuNet information is confidential and will not be released to third parties without written consent. Clients who have opted out in ImmuNet do not wish to have their immunization records in ImmuNet be made available to authorized ImmuNet users (health care providers, child care, or schools). Exceptions may be made for providers and authorized ImmuNet users by completing this form for the release of the opted-out client's immunization records.

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 provide complete information below to receive the immunization records. An e-mail, fax number, or address (to send the record to) is required for a prompt response.

Opted-Out Client's Information

First Name: _____ Last Name: _____

Middle Name (if applicable): _____ Maiden Name (if applicable): _____

Mother's Maiden Name: _____

Date of Birth: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ E-mail address: _____

Provider or Authorized ImmuNet User's Information

Information about the person requesting the release of opted-out record (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 opted-out client release of record request).

Relationship to Opted-Out Client: Provider / Authorized ImmuNet User

Reason for requesting the opted-out client's immunization records:

_____

First Name: _____ Middle Initial: _____Last Name: _____

Phone number: _____ Email address: _____

Select ONE method for record to be sent to you (*if you select more than one method, the first selected method will be used to send the record*):

☐ Secure E-mail (Maryland Department of Health uses Virtru)
Please provide an e-mail address: _____

☐ Fax
Please provide fax number: _____

☐ Mail
Please provide a mailing address:

Street Address: _____

City: _____ State: _____ Zip Code: _____

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 authorized to sign this release on the opted-out client's behalf.

☐ By checking this box, I also allow the Maryland Department of Health (MDH) to update the Opted-Out Client's Information (provided above) in ImmuNet for future record matching.

Signature of Person Requesting the Record: _____

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 email 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 e-mail service.
Once received, your request will be processed as quickly as possible. You should expect to receive the records in approximately 3-5 business days (note that regular mail may take longer).

MDH (For Official Use Only)
Date Received: _____ Initials: _____
Date Fulfilled: _____ Record: Sent / Demographics Updated / Not Found