Rescind 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 for yourself or your child at any time by completing the Opt-out form, or rescind the opt-out and have your/your child's information made available to your/your child's health care provider(s).

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 be made available to authorized users of ImmuNet.

Client's 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 rescind 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 rescind opt-out request).

☐ Same as Client's 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 confirm that I am the individual or parent/legal guardian of the client listed above. In the past, I chose to have the immunization information for myself/my child excluded from healthcare providers' access, however, at this time, I would like to have my/my child's immunization information be made available to my/my child's health care provider(s).

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

Signature of Person Rescinding 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 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, in no more than 5 business days.

MDH (For Official Use Only):
Date Received: _____
Date Fulfilled: _____
Initials: _____
Record: Opt-out Rescinded / Demographics Updated / Not Found