Decline or Start Sharing/Information Request Form (TB)

PLEASE CHECK (√) THE STATEMENT(S) BELOW THAT APPLY:

MY FULL NAME:	**RELATIONSHIP TO PATIENT** ☐ self ☐ parent/guardian
Name of Patient:	Patient's Address:
Patient's Date of Birth:	City/Zip Code:
	Phone:

DECLINE SHARING

☐ **I DECLINE to allow my/my child's immunization/ tuberculosis (TB) screening test record to be shared with other health care providers, agencies, or schools in the California Immunization Registry (CAIR).***

** Note: The immunization record/TB Tests may still be recorded in the registry for use by your physician's office. By law, public health officials can also access immunization/TB test records in the case of a public health emergency.*

START SHARING (Declined earlier, now have changed mind and wish to share.)

☐ **I ALLOW my/my child's immunization/TB test record to be shared with other health care providers, agencies, or schools in CAIR.**

REQUEST INFORMATION

☐ I REQUEST a list of agencies who have viewed my/my child's CAIR immunization/TB test record.

☐ I REQUEST to review or correct my/my child's CAIR immunization/TB test record. I understand that any changes made to this record must be verified by appropriate documentation from my health care provider.

Signature:	**Date:**

For office use only:
Fax this form to the California Immunization Registry (CAIR) at: 888-436-8320