

Decline or Start Sharing/Information Request

PLEASE CHECK (✓) THE STATEMENT(S) BELOW THAT APPLY:	
MY FULL NAME:	RELATIONSHIP TO PATIENT <input type="checkbox"/> self <input type="checkbox"/> parent/guardian
Name of Patient:	Patient's Street Address:
Patient Date of Birth:	Patient's City/Zip Code:
Patient ID (optional):	Patient County:
Patient Phone:	
DECLINE SHARING	
<input type="checkbox"/> 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).*	
<p><i>* 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.</i></p>	
START SHARING (Declined earlier, now have changed mind and wish to share.)	
<input type="checkbox"/> 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	
<input type="checkbox"/> I REQUEST a list of agencies who have viewed my/my child's CAIR immunization/TB test record.	
<input type="checkbox"/> 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:

Fax or email this form to the CAIR Help Desk at **1-888-436-8320**, CAIRHelpDesk@cdph.ca.gov