SHARING YOUR IMMUNIZATION INFORMATION
Objection (or Withdrawal of Objection) Form

The Massachusetts Immunization Information System (MIIS) keeps track of all immunizations which doctors and health care providers administer to patients in Massachusetts. The system has been created according to state law (M.G.L c. 111, Section 24M), and is operated by the Massachusetts Department of Public Health (MDPH). All information in the MIIS is kept confidential.

The law requires that immunizations be reported to the MDPH through the MIIS. It allows for the information to be shared among doctors and nurses providing your care, school nurses, local boards of health, staff at state agencies involved with immunization (including the WIC Program) and Health plans for immunization rate improvement and quality improvement efforts for each plan's membership. The MIIS enables a new health care provider to check what shots you or your child have received in the past from other providers. Your records will only be available to those involved in your care, who have a reason to know about them. You have the right to limit who else may see your or your child's information in the MIIS. If you prefer that your or your child's immunization history **not** be shared in this way, you need to **Object to sharing** your or your child's immunization information. If you have changed your mind or if you change your mind in the future and decide to share the information with more healthcare providers, you will need to **Withdraw your previous objection** to sharing your or your child's immunization information.

What it means to Object to the sharing of your or your child's immunization information:

- Your or your child's immunization history will **not** be seen by all healthcare providers in the MIIS.
- Your or your child's immunization information will still be in the MIIS, but only the provider(s) who gives you shots and the Department of Public Health will be able to see it.
- *Please note:* **You** will need to keep track of your or your child's immunization records if you change doctors or get immunizations from other health care providers.

How to Object to the sharing of your or your child's immunization information:

- Check the box next to "I OBJECT" on this form and complete the information requested.
- Give the completed form to your healthcare provider or send by fax or mail to the Department of Public Health at the contact information provided on this form.
- If you give the form to your healthcare provider, they must submit it to the MDPH via fax or mail.

What it means to Withdraw a previous objection to sharing your or your child's immunization information:

- You have changed your mind and decide to share your or your child's information with all of your or your child's healthcare providers who are using the MIIS.
- Once the Withdrawal has been processed your records will be made available to individuals involved in your care, who have a reason to know about them.

How to Withdraw a previous objection:

- Check "I WITHDRAW MY PREVIOUS OBJECTION" on this form and complete the information requested.
  - Give the completed form to your healthcare provider or send by fax or mail to the Department of Public Health at the contact information provided on form.
- If you give the form to your healthcare provider, they must submit it to the MDPH via fax or mail.

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Name of Patient: ____

☐ **I OBJECT** to the sharing of information in the MIIS about me or the individual for whom I have legal authority. I understand that this will keep my or my legal dependent's doctor or other health care provider from being able to check the MIIS for immunization information that comes from other health providers. I further understand that this objection will not prevent my dependent or myself from receiving immunizations.

☐ **I WITHDRAW MY PREVIOUS OBJECTION** to the sharing of immunization information in the MIIS about me or the individual for whom I have legal authority. I understand that by signing and submitting this form, the MIIS will be able to share immunization information with my or my dependent's doctor(s) or other health care providers and other persons allowed by law to view this information.

Information on Record being updated: This information is necessary to ensure the identity of the individual whose record is being updated (*i.e. you, your child, or individual over whom you have legal authority*).

NAME:
____
LAST FIRST MIDDLE

DATE OF BIRTH: _ _/_ _/_ _ _ _ **GENDER:** _________________ **PHONE NUMBER:** ___________________________
MM/DD/YYYY

ADDRESS: ____
STREET CITY STATE ZIPCODE

MOTHERS MAIDEN NAME: ____

IF AVAILABLE FOR INDIVIDUAL YOUNGER THAN 18 YEARS OF AGE

Information on Requestor of the record: This information is necessary to ensure the individual/agency has the legal authority to complete this record request.

☐ **Requestor same as above** – skip to **Signature of Requestor**, otherwise complete section below.

NAME:
____
LAST FIRST MIDDLE

ADDRESS: ____
STREET CITY STATE ZIPCODE

PHONE NUMBER: _________________

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I authorize the Massachusetts Department of Public Health to release confirmation of record processing to the following:

Email: ____

If you do not have access to an email, you may request confirmation via Fax or Phone:

Fax: __________________________

Phone: ________________________

Signature of Requester: I am requesting to update the data sharing of my own record, or I am the parent, guardian, or other person authorized to act for the person whose record I am requesting. I certify under the penalties of perjury that the information I am providing to request the identified immunization record is true to the best of my knowledge.

Signature:____Date:________________________

Health Care Provider Use Only – please enter your contact information, mail or fax a copy of the form to MDPH, and keep the original for the patient's record:

☐ CHECK TO CONFIRM THE DATA SHARING STATUS WAS CHANGED IN THE MIIS FOR THE ABOVE PATIENT. If an objection, change the patient's data sharing status to No. If a withdrawal, change patient's data sharing status to Yes.

Staff Member's Name:____

Facility or Practice Name:____

Vaccine PIN#:____________________ Staff Phone#: (____)___________ext:________

Please submit this form by mail or fax to the Massachusetts Department of Public Health:

Mailing Address: My Vax Records

Massachusetts Immunization Information System (MIIS)
Immunization Program
Massachusetts Department of Public Health
305 South Street
Jamaica Plain, MA 02130

Fax: 857-323-8321