

My Vax Records Clinical Immunization Record Amendment Request

NOTE: Before beginning this process, it may be faster to request any updates to your immunization record directly from your current healthcare provider or to utilize our electronic amendment form request system to request the Massachusetts Department of Public Health (MDPH) make the clinical updates to your immunization record. You may access the electronic system at the following link: <https://myvaxrecords.mass.gov/pages/Request>. If that is not possible, please read this information and complete the form below:

The Massachusetts Immunization Information System (MIIS) is a web-based system that keeps track of all immunizations healthcare providers administer to children and adults in Massachusetts. The system was established in 2011 and is operated by the Massachusetts Department of Public Health (MDPH) according to state law ([M.G.L c. 111, Section 24M](#)).

All individual information in the MIIS is kept confidential in accordance with applicable law.

To request a Clinical Immunization Record Amendment, please submit the following and allow up to 10 business days for processing:

- The “My Vax Records Clinical Immunization Record Amendment Request Form,” signed, completed and notarized
- A photocopy of your driver’s license, or other state-issued ID, with the license number shielded or removed
- If the amendment request is for any vaccine other than COVID-19 or you are requesting to add your entire COVID-19 vaccine history to the MIIS, the following is required
 - Proof of the correction in the form of a letter signed and dated by a physician, nurse practitioner, physician assistant, or designee licensed in the United States which specifies demographic updates or vaccination updates including the month and year of administration and the type/name of the vaccine(s) administered.
- If the amendment request is for correcting a COVID-19 vaccine record that is already in the MIIS or adding a missing COVID-19 vaccine from a two-dose series to the MIIS, the following is required:
 - Proof of the correction needed such as CDC Covid-19 Card, documentation from your healthcare provider or organization such as a screen shot or print out of your immunization record. We are not able to accept International Immunization Records. If applicable, please submit international records to your healthcare provider for evaluation.

MDPH cannot amend the clinical information associated with your MIIS immunization record without the documentation listed above.

Please return the completed paperwork to MDPH by mail or fax:

My Vax Records
Massachusetts Immunization Information System (MIIS)
Massachusetts Department of Public Health, Immunization Division
305 South Street, Jamaica Plain, MA 02130
FAX: 857-323-8321

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Individual or Dependent 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: _____

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: _____

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SIGNATURE: _____ DATE: _____

Signature of Requestor: I am requesting an update to the clinical information associated with my own record, or I am the parent, guardian, or other person legally authorized to act for the person whose record I am requesting. I certify under the penalties of perjury that the information I am providing is true to the best of my knowledge.

Verification: To be Completed by a Certified Notary Public

OFFICIAL SIGNATURE AND SEAL OF NOTARY:

STATE OF _____

_____ County, ss.

On this ____ day of _____, 20____,
before me, the undersigned notary public, personally
appeared _____
proved to me through satisfactory evidence of
identification, which were _____, to
be the person whose name is signed on this document in
my presence. And has produced documentation to confirm
legal authority if requesting on behalf of another person.

Notary Public

Commission #

My commission expires

Description of requested clinical change to MIIS record:

Please explain what change you are requesting:
