

## **Record Not Found in My Vax Records Patient Portal**

**NOTE:** Before beginning this process, it may be faster to request that your healthcare provider investigate your unfound immunization record or to utilize our electronic amendment form request system to submit a request for the Massachusetts Department of Public Health (MDPH) to further investigate your unfound vaccination 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 MDPH Demographic Immunization Record Amendment, please submit the following and we will make every effort to respond within 10 business day.

- A Record Not Found in My Vax Records Patient Portal Form, completed and signed and notarized
- A photocopy of your driver's license, or other state-issued ID, with the license number shielded or removed
- If you have experienced a name change in the last 10 years, please submit proof of legal name change
- If your new address is not reflected on your ID, please submit proof of your new address (e.g. a copy of a utility bill)

**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

**DO NOT SUBMIT VIA EMAIL – MIIS EMAIL IS NOT SECURE**

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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 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

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.

#### OFFICIAL SIGNATURE AND SEAL OF NOTARY:

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Commission #

\_\_\_\_\_  
My commission expires

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### Demographic Identity Verification Form

**Please complete as much of the following information as possible. MDPH will utilize this information to attempt to find your record. You may skip any questions that are not relevant for you.**

Current address: \_\_\_\_\_  
\_\_\_\_\_

Former two addresses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Former name (if applicable): \_\_\_\_\_

Current phone: \_\_\_\_\_

Former phone numbers (list any you can remember): \_\_\_\_\_

Current email address: \_\_\_\_\_

Former email address: \_\_\_\_\_

Last Vaccine Received: \_\_\_\_\_

Date Administered: \_\_\_\_\_

Administering Site: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Primary Care Facility: \_\_\_\_\_