Maryland
DEPARTMENT OF HEALTH

Center for Immunization
Maryland Immunization Information System (ImmuNet)

**ImmuNet Rescind Opt-out Form**

Maryland's Immunization Information System (ImmuNet) is a secure web-based registry operated by the Center for Immunization at the Maryland Department of Health (MDH). ImmuNet information is confidential, HIPAA and FERPA compliant, and available only to authorized users, and will not be released to third parties without written consent.

If you previously chose to opt out of ImmuNet (not to disclose your/your child's immunization information to authorized users of ImmuNet), but wish to rescind your previous opt out so your/your child's information in ImmuNet can be made available to your/your child's healthcare providers again, you must complete this Rescind Opt-out form.

Please complete the information for the person whose vaccination record be made available to authorized users of ImmuNet.

**Client's Information**

_____
First Name Middle Name Last Name

_____ _____
Maiden Name (if applicable) Mother's Maiden Name

_____ _____
Date of Birth Gender

_____
Address City State Zip Code

(____)_____ _____
Phone number (Home / Cell) Email address

**Requestor's Information**
Information about the person completing the rescind opt-out request (this information will be used to contact you if this form is incomplete/unclear, or if more information is needed to match the record, and will be filed as legal documentation of the rescind opt-out request).

☐ Same as Client's Information above (if not, please provide the information below)

Relationship to Client: _____

_____

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Requestor's First Name | Requestor's Middle Name | Requestor's Last Name

Requestor's Address | City | State | Zip Code

(____)_____ | _____
Requestor's Phone number (Home / Cell) | Requestor's Email address

**Requestor's Agreement/Signature**

☐ By checking this box, I declare under penalty of perjury under the laws of the state of Maryland that this information is true and correct, and that I am the client, or am authorized to make decisions for the client listed on this form.

☐ By checking this box, I confirm that I am the individual or parent/legal guardian of the client listed above. In the past, I chose to have the immunization information for myself/my child excluded from healthcare providers' access, however, at this time, I would like to have my/my child's immunization information be made available to my/my child's health care provider(s).

Signature of Person Rescinding the Opt-out: _____

Date Completed: _____

If you wish to keep a completed copy of your form, please make a copy before submitting the form.

**Mail or Fax to**
Maryland Department of Health
Center for Immunization - ImmuNet
201 West Preston Street 3rd Floor, Baltimore, MD 21201
Fax: (410) 333-5893

Please mail or fax the completed form. Do not email the completed form as it places you at risk for exposing your sensitive information. E-mailed forms will not be accepted unless you are able to use an encrypted e-mail service. It is preferred if you can fill out the online form at health.maryland.gov/immunet

Once received, your request will be processed as quickly as possible, in no more than 5 business days.

**MDH (For Official Use Only):**
Date Received: _____ | Date Fulfilled: _____
Initials: _____ | Record: Opt-out Rescinded / Not Found