Maryland
DEPARTMENT OF HEALTH

Center for Immunization
Maryland Immunization Information System (ImmuNet)

ImmuNet 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 do not want to disclose your/your child's immunization information to authorized users of ImmuNet, you may opt out for yourself or your child at any time by completing this Opt-out form. Should you decide later to rescind this opt-out and have your/your child's information made available to your/your child's health care provider(s) in ImmuNet, you must complete a Rescind Opt-out form.

Please complete the information for the person whose vaccination record should not be shared with 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 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 opt-out request).

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

Relationship to client: _____

_____
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 understand that my request to opt-out of ImmuNet for myself, my minor child, or person for whom I am a legal guardian means that the client's information will not be available to or shared with authorized health care providers. Data that has been previously shared or released cannot be retracted.

☐ By checking this box, I understand that the Maryland Department of Health (MDH) and Maryland's Local Health Departments (LHDs) will still have access to the client's record. Physician or school requests for information must be accompanied by a signed medical release.

☐ By checking this box, I understand that once opted out, I will not be able to access my or my child's records via the secure portal MyIR (at myirmobile.com) and will need to complete a Records Request form each time I need my or my child's records.

Signature of Person Requesting 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 e-mail 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 email 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: _____ Initials: _____
Date Fulfilled: _____ Record Status: Opted Out / Not Found