COUNTY OF MARIN HEALTH CARE PROVIDER'S DISCLOSURE TO PATIENT/PARENT/GUARDIAN ON IMMUNIZATION REGISTRY RECORD SHARING
(Prepared Pursuant to Health and Safety Code Section 120440)

This office/clinic participates in a computerized immunization registry database and may share immunization and tuberculosis information about you or your child with the Public Health Department, the State Department of Health Services, and others involved in your care including doctors, clinics, and hospitals. These entities can use this information only to determine what vaccines you need; remind you when vaccines are due; and get a report of patients who are or are not up-to-date on their vaccines. This information may also be shared with the following entities if they request it: CAL-Works public assistance program; schools and child care facilities to help prove your child has had the vaccines required for entry; WIC programs to determine vaccine doses due; your health care plan to help process insurance payments; and others as specifically authorized by law.

The only information that will be shared is name, date of birth, birthplace, vaccines received, serious vaccine reactions, and tuberculosis testing and results. We will share address and phone number if needed to make sure it is the correct person's record.

All of the entities listed above who ask for and receive this information are required by law to keep it confidential and use it only for the reasons listed above. Also, you have these rights:

- **To review your immunization information, ask questions, and correct errors.**
- **To obtain names and addresses of entities with whom your information has been shared.**
- **To choose not to receive reminder notices when vaccines are due.**
- **To choose not to share your information in the registry or to stop sharing at any time.**

REFUSAL TO SHARE INFORMATION/REFUSAL TO RECEIVE REMINDERS/ REVERSAL OF REFUSAL TO SHARE
(Initial the statements that reflect your preferences)

________ Initials **I do want to share the information described above with the Public Health Department Immunization Registry or State Department of Health Services.**

________ Initials **I do <u>not</u> want to share the information described above with the Public Health Department Immunization Registry or State Department of Health Services.**

Patient's Name____

Signature of Patient/Parent/Guardian _____________________________________ Date _______________