Massachusetts Immunization Information System

SHARING YOUR IMMUNIZATION INFORMATION
Objection (or Withdrawal of Objection) Form

The Massachusetts Immunization Information System (MIIS) keeps track of all immunizations which doctors and health care providers give to patients in Massachusetts. The system has been created according to state law (M.G.L c. 111, Section 24M), and is operated by the Massachusetts Department of Public Health (MDPH). All information in the MIIS is kept confidential.

The law requires that immunizations be reported to the MDPH through the MIIS. It allows for the information to be shared among doctors and nurses providing your care, school nurses, local boards of health, and staff at state agencies involved with immunization (including the WIC Program). The MIIS enables a new health care provider to check what shots you or your child have received in the past from other providers. Your records will only be available to those involved in your care, who have a reason to know about them. You have the right to limit who else may see your or your child's information in the MIIS. If you prefer that your or your child's immunization history **not** be shared in this way, you need to **Object to sharing** your or your child's immunization information. If you have changed your mind or if you change your mind in the future and decide to share the information with more healthcare providers, you will need to **Withdraw your previous objection** to sharing your or your child's immunization information.

What it means to Object to the sharing of your or your child's immunization information:

- Your or your child's immunization history will **not** be seen by all healthcare providers in the MIIS.
- Your or your child's immunization information will still be in the MIIS, but only the provider(s) who gives you shots and the Department of Public Health will be able to see it.
- *Please note:* **you** will need to keep track of your or your child's immunization records in the event that you change doctors or get immunizations from other health care providers.
- **How to Object to the sharing of your or your child's immunization information:**
    - Check the box next to "I OBJECT" on the other side of this form and complete the information requested.
    - Give the completed form to your healthcare provider or send by fax or mail to the Department of Public Health at the contact information provided on the other side of this form.

What it means to Withdraw a previous objection to sharing your or your child's immunization information:

- You have changed your mind and decide to share your or your child's information with all your or your child's healthcare providers who are using the MIIS.
- Once the Withdrawal has been processed your records will be made available to individuals involved in your care, who have a reason to know about them.
- **How to Withdraw a previous objection:**
    - Check "I WITHDRAW MY PREVIOUS OBJECTION" on the other side of this form and complete the information requested.
    - Give the completed form to your healthcare provider or send by fax or mail to the Department of Public Health at the contact information provided on the other side of this form.

Commonwealth of Massachusetts Department of Public Health

Immunize MA

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Name of Patient: _____

☐ **I OBJECT** to the sharing of information in the MIIS about me or my child. I understand that this will keep my or my child's doctor or other health care provider from being able to check the MIIS for immunization information that comes from other health providers. I further understand that this objection will not prevent my child or me from receiving immunizations.

☐ **I WITHDRAW MY PREVIOUS OBJECTION to the sharing** of immunization information in the MIIS about me or my child. I understand that by signing and submitting this form, the MIIS will be able to share immunization information with my or my child's doctor(s) or other health care providers and other persons allowed by law to view this information.

Patient's Information (this information is necessary to properly identify the patient):

Name:_____ _____ __ Date of Birth:___/___/_____
Last First MI MM / DD / YYYY

Mother's Maiden Name:_____ Gender: _____
For child younger than 18 yrs of age

Address:_____ Phone#: (____)_____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Information (required if form is completed for a child younger than 18 years of age):

Name:_____ _____ __ Date of Birth:___/___/_____
Last First MI MM / DD / YYYY

Relationship to Patient: _____ ☐ CHECK IF ADDRESS & PHONE # ARE SAME AS PATIENT'S

Address:_____ Phone#: (____)_____

City: _____ State: _____ Zip Code: _____

Signature of Patient, or Parent/Guardian (if child is younger than 18 years of age)**:**

Signature:_____ Date:_____

Health Care Provider Use Only – please enter your contact information, mail or fax a copy of the form to MDPH, and keep the original for the patient's record:

☐ CHECK TO CONFIRM THE DATA SHARING STATUS WAS CHANGED IN THE MIIS FOR THE ABOVE PATIENT. If an objection, change the patient's data sharing status to No. If a withdrawal, change patient's data sharing status to Yes.

Staff Member's Name:_____

Facility or Practice Name:_____

Vaccine PIN#:_____ Staff Phone#: (____)_____ ext:_____

Please submit this form by mail or fax to the Massachusetts Department of Public Health:

Mailing Address: Massachusetts Immunization Information System (MIIS)
Immunization Program
Massachusetts Department of Public Health
305 South Street
Jamaica Plain, MA 02130

Fax: 857-323-8321

MDPH Date Received:_____; Date Processed:_____; Initials:____