Massachusetts Immunization Information System

MIIS

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.

All information in the MIIS is kept confidential among healthcare and other professionals involved in immunization. The law 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). For example, it allows a new doctor to check what shots you have gotten in the past from other doctors. It allows an emergency room nurse who has never seen you before to check the MIIS to see if you have had a certain kind of shot. Your records will only be available to those involved in your care, who have a reason to know about them.

You may prefer that your immunization history **not** be shared in this way. If so, please check the box next to "I OBJECT" below and complete the information on the other side of this form. Then give the form to your doctor or other 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. If you object, your 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 in your community.

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, check "I WITHDRAW MY PREVIOUS OBJECTION" below and give the form to your doctor or other healthcare provider (or the MDPH).

Name: _____

☐ **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 being able to receive 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.

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Individual or Child Information (this information is necessary to properly identify you or your child)

Name: _____
Last First Middle

Date of Birth: _____ Mother's Maiden Name: _____
MM/DD/YYYY For child younger than 18 yrs of age.

Sex: _____ Phone Number: (_____) _____

Street Address: _____

City: _____ State: _____ ZIP: _____

If this form is being completed for a child younger than 18 years of age, please provide Parent/Guardian contact information:

Name: _____
Last First Middle

Relationship to Child: _____ Phone Number: (___ ___) _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Signature of Individual or Parent/Guardian:

Signature: _____ Date: _____

Please return this form to your health care provider. Alternatively, you may submit this form directly to the Department of Public Health at the address below:

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

Fax: **617-983-4301**

Health Care Provider Use Only: Please enter your contact information, mail or fax a copy of **both pages** of the form to MDPH, and keep the original for your records:

Facility or Practice Name: _____

PIN #: _____ _____ _____ _____ _____ Phone: (_____) _____

☐ Check this box if you have changed the Data Sharing Status in the MIIS for the above mentioned individual.