Consent to share vaccination information

(for patients 19 or older)

This form is to give or not give consent to your health care provider, The Institute for Family Health, to release your vaccination and identifying information to the New York City Immunization Registry and New York State Immunization Information System.

The purpose of the city and state registries is to assist in your medical care and to record the vaccinations that you have had or will receive in the future. For more information about the New York City Immunization Registry and the New York State Immunization Information System, please see page 2.

Please read your consent choices carefully. Then, choose one and write an X next to your choice:

☐ **I GIVE CONSENT** for the Institute for Family Health to send information about vaccinations I receive to the New York City and New York State immunization registries. I understand that New York City and State may use information about my vaccinations, but not my name or identifying information, for research or public health purposes. I understand I can change my consent choice at any time by submitting a new consent form with my new consent choice.

☐ **I DO NOT GIVE CONSENT** for the Institute for Family Health to send information about vaccinations I receive to the New York City and New York State immunization registries. I understand that New York City and State may use information about my vaccinations, but not my name or identifying information, for research or public health purposes. I understand I can change my consent choice at any time by submitting a new consent form with my new consent choice.

My questions have been answered and I have been provided a copy of this form.

Patient's Name: _____ Patient's Date of Birth: _____

Patient Signature: _____ Date: _____

Name of Legal Representative, if applicable: _____

Relationship of Legal Representative, if applicable: _____

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Please see below for more information about the New York City Immunization Registry and the New York State Immunization Information System:

- The purpose of the city and state registries is to assist in your medical care and to record the vaccinations that you have had or will receive in the future.
- Your vaccination information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes.
- Information used for quality improvement or any research purposes will have your personal identifying information removed.
- Your vaccination information may be released to:
  - You
  - Your health insurance organization
  - State and local health departments
  - The school that you are registered to attend
  - Authorized medical providers that deliver your medical care
- There will be no effect on your treatment, payment, or enrollment for benefits if you choose not to participate in the registry.
- Your consent may be withdrawn at any time by using the form provided.
- Information about your vaccinations may be received by the registry with your consent will remain in the registry if you later choose to withdraw your consent. However, future vaccinations will not be recorded in the registry.

For more information about this form, please speak to registration.