Opt-Out Form
PhilaVax

Department of Public Health
CITY OF PHILADELPHIA

November 2020 | **vaccines@phila.gov**

Use this form to document patients who choose to **opt-in** or **opt-out** of PhilaVax. Please complete this form in its entirety.

Patient Information

Last Name	First Name	Middle Name
Date of Birth		
Address		
City	State	Fax Number

Check one:

☐ **I refuse** to permit my immunization information/my child's immunization information to be shared with providers participating in PhilaVax

☐ **I authorize** PhilaVax and its staff to share my immunization information/my child's immunization information with providers participating in PhilaVax

Legal Guardian Last Name	Legal Guardian First Name
Patient or Legal Guardian Signature	Date

Please fax this form to: (215) 238-6944

Or email to: PhilaVax@phila.gov

PhilaVax

PDPH USE ONLY

Date Received:

Approved?:

Entered by:

Clinic Code: