# PhilaVax

## Opt-Out Form

use this form to document patients who choose to opt-in or opt-out of PhilaVax. Please complete this formin its entirety. Please print clearly.

### Patient Information

| Last Name | First Name | Middle Name |
|---|---|---|
| Date of Birth | | |
| Address | | |
| City, State | | ZIP |

### 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 |

**Fax Number:** 215-238-6944

**Email:** PhilaVax@phila.gov

**Mail:** PhilaVax
500 S. Broad St., 2nd Fl.
Philadelphia, PA 19146

**For Official Use Only**

Reviewed By: ____________________

Date: ____________________________