

Janet T. Mills
Governor

Sara Gagné-Holmes
Acting Commissioner



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ImmPact Patient Non-Participation Form

Patient's First Name, Middle Initial, Last Name

Date of Birth

Patient's complete mailing address

City/Town

State

Zip Code

1. I have been informed that the above-named person is included in Maine's Immunization Information System, called ImmPact. By signing this form, I choose not to participate at this time.
2. I understand it is my responsibility to notify the provider at each visit that the above opted out of ImmPact. I also understand if I change health care providers, I will notify them of my choice to opt out.
3. I understand my responsibility to maintain my personal immunization record and that of my minor child for whom I am the parent or legal guardian.
4. I understand that I or my child may continue to receive immunizations through my health care provider, but because I choose not to participate in ImmPact, those immunization records will not be entered into ImmPact. My immunization record will be available to me only through my health care provider.
5. I understand that once I choose not to participate, records currently held in ImmPact will be made available to the State Health Officer or those designated by the State Health Officer only in the event of an officially declared public health emergency.
6. I understand that in the future, I can rescind this opt out decision and I can choose to participate in ImmPact.

Signature of Patient (or parent/guardian)

Date

Printed Name of Patient (or parent/guardian)

Date

Relationship to Patient (I am the patient; minor's parent or guardian; power of attorney of patient; etc.)

MIP use only: *Date Received:* _____ *Initials:* _____