Request to Prevent Sharing of LINKS Patient Record

Complete this form to prevent sharing of the immunization record from LINKS with authorized users other than the primary care provider or local health unit. Please print.

I _____/_____wish to prevent sharing of
Parent/Guardian/Self First Name Last Name

_____/_____/_____ ___/_____/_____ M F
Patient First Name Middle Name Last Name Date of Birth (m/d/yyyy) Gender
(Circle one)

_____/_____/_____/_____
Patient Address City State Zip Code

Immunization record contained in the Louisiana Immunization Network (LINKS) System with any authorized user other than the primary care provider and local public health unit.

I understand that the immunization records will not be shared through LINKS with any other authorized health care providers, health insurers, schools, day care centers, early learning centers, or publicly funded programs other than the primary care provider or my local public health unit. I understand that if I choose to permit disclosure from LINKS to other authorized users, I can do so at any time.

_____ _____
Signature Date (m/d/yyyy)

Mail it to:
Louisiana Department of Health
Office of Public Health
Immunization Program -LINKS
1450 Poydras St., Suite 1938
New Orleans, LA 70112