NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization

Withdrawal of Consent for Participation in NYSIIS for Individuals 19 Years of Age or Older

I withdraw my consent for inclusion of my immunization information and identifying information in the New York State Immunization Information System (NYSIIS). I understand that records of immunizations received by NYSIIS with my consent will remain in NYSIIS; however, information about any future immunizations I receive will not be recorded in NYSIIS.

Name

Date of Birth

Address

Signature

Send this completed form to:

New York State Immunization Information System
New York State Department of Health
Corning Tower, Room 678
Albany, NY 12237