

WITHDRAWAL OF CONSENT FOR PARTICIPATION IN  
NYSIIS FOR INDIVIDUALS 19 YEARS OF AGE OR OLDER

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**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: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

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