**Virginia Immunization Information System (VIIS)**
**Opt-Out of VIIS form**

*This form is required to request that a person's immunization history be removed from VIIS and that no further immunization data be accepted into VIIS*

**Name of Client:** _____ _____ _____
LAST FIRST MIDDLE

**Date of Birth**: _____ **Sex**: _____ **Race**: _____
MM/DD/YYYY M/F or Unknown

**Name of Parent or Guardian**: _____ _____ _____
LAST FIRST MIDDLE

**Relation**: _____ Telephone Number: _____ _____
PARENT OR GUARDIAN AREA CODE NUMBER

**Street Address**: _____

**City**: _____ **State**: _____ **ZIP**: _____

I request this person be removed from the Virginia Immunization Information System (VIIS). I understand the state will remove all immunization data on this person from VIIS as a result of this action. **VIIS will retain only core demographic information necessary to identify the client chosed to opt out of VIIS.** This information is necessary to enable VIIS to filter and refuse entry of immunization information for the client. Additionally, any prior immunization records associated with the client will be deleted from VIIS. I understand that if I choose to have my child re-entered into VIIS, I can do so at any time.

This Opt-Out form will be maintained in the Virginia Department of Health, Division of Immunization Program's office. The Virginia Department of Health, Division of Immunization Program must receive a completed Opt-Out form before the client is removed from VIIS.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE (MM/DD/YYYY)

THIS FORM MUST BE COMPLETED AND MAILED TO THE FOLLOWING ADDRESS.

VIIS-Opt-Out
Virginia Department of Health
Division of Immunization
109 Governor Street, Room 314W
Richmond, Virginia 23219

**Virginia Immunization Information System (VIIS)**
**Opt-In to VIIS form**

*This form is required to allow a person who has previously opted-out of VIIS to opt back into VIIS thereby allowing collection if immunization data on the person.*

**Name of Client:** _____ _____ _____
LAST FIRST MIDDLE

**Date of Birth**: _____ **Sex**: _____ **Race**: _____
MM/DD/YYYY M/F or Unknown

**Name of Parent or Guardian**: _____ _____ _____
LAST FIRST MIDDLE

**Relation**: _____ Telephone Number: _____ _____
PARENT OR GUARDIAN AREA CODE NUMBER

**Street Address**: _____

**City**: _____ **State**: _____ **ZIP**: _____

I request this person be reinstated into the Virginia Immunization Information System (VIIS). I understand this action will allow the state to add all immunization data on this person from participating providers in VIIS. VIIS will be the official source of immunization history for this person.

This Opt-In form will be maintained in the Virginia Department of Health, Division of Immunization Program's office. The Virginia Department of Health, Division of Immunization Program must receive a completed Opt-In form before action is taken to add the person into VIIS.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE (MM/DD/YYYY)

THIS FORM MUST BE COMPLETED AND MAILED TO THE FOLLOWING ADDRESS.

VIIS-Opt-In
Virginia Department of Health
Division of Immunization
109 Governor Street, Room 314W
Richmond, Virginia 23219