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

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

Name of Client: _____ _____ _____
LAST FIRST MIDDLE

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

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 for this person from VIIS as a result of this action. **VIIS will retain only core demographic information necessary to identify the client chose 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 myself or 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 (Parent or Guardian if client is a minor) DATE (MM/DD/YYYY)

<u>THIS FORM MUST BE COMPLETED AND MAILED TO THE FOLLOWING ADDRESS</u>:

Virginia Immunization Information System
Virginia Department of Health
Division of Immunization
109 Governor Street, Room 314W
Richmond, VA 23219