NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization for Individuals 19 Years of Age or Older

Consent For Participation in NYSIIS
For Individuals 19 Years of Age or Older

The New York State Immunization Information System (NYSIIS) is a confidential, computerized system that contains immunization records and allows authorized users access to a person's shot record. Strict federal and state laws protect the privacy of your personal information in the system. The benefits of participating in NYSIIS include:

- Your health care provider can use NYSIIS to be sure that you receive the needed immunizations, and proper medical treatment is received when needed.
- There will be a permanent and easily accessible record of your immunizations.

Participation in NYSIIS for people 19 years of age and older is voluntary, so your consent is needed. If you want to participate, please carefully read the consent below and sign in the space provided. For additional information about this consent, please call (518) 473-2839.

My signature below gives my consent for the **Davis Health Center** to release my immunization(s) and identifying information to the New York State Immunization Information System (NYSIIS). I understand the purpose of NYSIIS is to assist in my medical care and to record the immunizations that I have had or will receive in the future. My immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.

The immunization information in NYSIIS may be released to the following: myself, my health insurance plan, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

I understand that there will be no effect on my treatment, payment, or enrollment for benefits if I choose not to enroll in NYSIIS. **This consent may be withdrawn at any time by using the form provided.** Information about immunizations received by NYSIIS with my consent will remain in NYSIIS if I later choose to withdraw my consent. However, future immunizations will not be recorded in NYSIIS.

Print Name

Date of Birth

Signature

Date

Student ID

Your birth mother's maiden name is required by New York state public health law 2168. Please print legibly

Mother's first name:

Mother's (Maiden) Last name:

_____

_____

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