NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all
Department of Health and Human Services

New Hampshire Immunization Information System (NHIIS) Withdrawal Form

Fax or mail this form to: New Hampshire Immunization Program, 29 Hazen Drive, Concord, NH 03301
Attn: Registry Administrator, fax: 603-696-3266

Vaccine Recipient Information (AS IT APPEARS IN NHIIS)- To be completed by the participant or parents/Legal guardian				
Name of the Vaccine Recipient/Participant (Print)		Date of Birth (MM/DD/YYYY)		NHIIS Patient ID (If known)
Street Address	**City**	**State**	**Zip code**	**Phone number or Email address**

Acknowledgement:

- I understand that this withdrawal from participation in the registry will not prevent me or my child from receiving immunizations/vaccinations.
- I understand withdrawing will delete all existing vaccine information within the NHIIS for myself or for my child. This is a permanent deletion that cannot be undone.
- I understand that I may reverse my decision by completing a "Reverse Previous Decision not to Participate in the New Hampshire Immunization/Vaccination Registry" form with my current health care provider.
- I understand that it is my responsibility to inform my other health care providers of my decision to withdraw from the registry so that no future immunization/vaccination information is reported to the NHIIS.
- Patients who choose to withdraw from participation in the registry are not relieved from the obligation to comply with current immunization requirements set forth in RSA 141-C:20-a and He-P 301.14.

_____ (initials Here) **I withdraw my/my child's participation and seek removal of all my/my child's information from the NH vaccination registry, known as the NH Immunization Information System (NHIIS).**

Name of Parent or Legal Guardian (if participant <18 years old) (Print)	**Relationship to participant**	**Signature of Participant, Parent or Legal guardian (sign in presence of Notary)**	**Date of Request**

Healthcare Provider		**Public Notary**
Name of the Facility or Clinic and Clinic ID		***Subscribed and sworn before me this***
Name of Healthcare Provider	**OR**	_____ ***Day of*** _____ ***(Month),*** _____ ***(Year)***
Signature of Healthcare Provider		***Notary's Signature and Seal***
Date:_____		***Date My Commission Expires:***_____

Note: In the event that the NH Department of Public Health was the medical provider (i.e. State run COVID-19 clinic), a copy of vaccination(s) provided by the Department/Department's authorized agent will be retained in a separate HIPAA compliant system for a period of 7 years for adults and 7 years or until the minor reaches age 19 for minors in order to comply with Med (501.02(f) (8) and He-P 802.06 (h).