NH DIVISION OF Public Health Services
Department of Health and Human Services

New Hampshire Immunization Information System (NHIIS) Withdrawal of Information 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 registrant or parents/Legal guardian				
Name of the Vaccine Recipient/Registrant (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.
- I understand withdrawing will delete all existing immunization information within the NHIIS for myself or for my child. This is a permanent deletion that cannot be undone.
- I understand that it is my responsibility to inform my or my child's health care provider(s) of the decision to withdraw from the registry.
- I understand that individuals 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.
- I understand that this withdrawal from NHIIS will not withdraw information from another state's/territory's IIS. It is my responsibility to contact any other state's/territory's IIS in which the registrant has received immunization to request withdrawal of information from that state/territory as exchange of immunization information may have occurred.

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

Name of Parent or Legal Guardian (if registrant <18 years old) (Print)	**Relationship to registrant**	**Signature of Registrant, 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)***
		Notary's Signature and Seal
_____ _____ ***Signature of Health Care Provider 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 Immunization(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 in order to comply with Med 501.02(f)(8). The Department is also obligated to maintain a record of transactions, separate from the registry, in accordance with HIPAA record retention requirements.