OHIO DEPARTMENT OF HEALTH

246 North High Street
Columbus, Ohio 43215

614/466-3543
www.odh.ohio.gov

John R. Kasich / Governor

Request to be Removed from the Impact Statewide Immunization Information System (ImpactSIIS)

In order to be removed from the immunization registry and appointment reminder system, called ImpactSIIS, the Ohio Department of Health must receive this form signed by the patient, or if the patient is a minor, the parent or legal guardian. Immunization data for the patient listed below will be blocked from being included in the registry. Because there are times when more than one person born on the same date are given the same name, we collect basic personal information to match against incoming data to reject (block) any that may be reported to us by a medical care provider. The personal information will be kept confidential and will not be available to users of the system.

PLEASE PRINT Use formal names with nicknames in parenthesis, for example, William (Bill).

Patient's Information

Name (Last, First and Middle): _____, _____ _____

Address: _____

City: _____ State: _____ Zip: _____-_____

Date of Birth: __ __ / __ __ /__ __ __ __ Social Security Number*: __ __ __ - __ __ - __ __ __ __

Telephone Number: (__ __ __) __ __ __ - __ __ __ __

Mother's (or Guardian's) Information

Name (Last, First and Middle): _____, _____ _____

Date of Birth: __ __ / __ __ /__ __ __ __ Social Security Number*: __ __ __ - __ __ - __ __ __ __

Maiden Name: _____

Father's (or Guardian's) Information

Name (Last, First and Middle): _____, _____ _____

Date of Birth: __ __ / __ __ /__ __ __ __ Social Security Number*: __ __ __ - __ __ - __ __ __ __

* Supplying the Social Security Numbers is optional. The Social Security Numbers increase the quality of the data block.

By completing and signing this form, I am requesting the removal of the immunization records for the patient named above from the Immunization Registry and Appointment Reminder System. If I am signing on behalf of a minor, I certify that I am legally authorized, under penalty of law, to exercise the rights of the minor identified in this document.

Signature: _____

Date: __ __ / __ __ /__ __ __ __

This form must be sent to:
Ohio Department of Health
Immunization - Impact SIIS
35 East Chestnut Street
Columbus, OH 43215

Telephone: (614) 466-4643
Facsimile: (614) 728-4279

An Equal Opportunity Employer/Provider