Adult Opt Out
North Dakota Immunization Information System

The North Dakota Immunization Information System (NDIIS) is a confidential, electronic system that allows authorized users, such as healthcare providers, pharmacies and long-term care facilities, to view and enter immunization records. Adults 19 and older have the right to opt out of the NDIIS. By opting out, you are indicating that you do not want any of your immunizations, including both past immunizations as well as newly administered immunizations, to be entered in to the NDIIS. By choosing not to have your immunizations in the NDIIS, you are not allowing any healthcare provider that you see to be able to view your immunization history in the NDIIS, which could lead to additional, unnecessary immunizations. You also may be unable to find your immunization record for future school or employment. Once you have opted out of the NDIIS you can choose to opt back in, however there may be information missing from your immunization history.

Please complete this form by clearly printing all information.

Adult opt-out requests should either be mailed or emailed to the North Dakota Department of Health. **Requests will not be accepted over the telephone.**

North Dakota Department of Health
Immunization Program
2635 East Main Ave., P.O. Box 5520
Bismarck, ND 58506-5520

Email Address: NDIIS@nd.gov

NORTH DAKOTA IMMUNIZATION INFORMATION SYSTEM (NDIIS) ADULT OPT OUT

NORTH DAKOTA DEPARTMENT OF HEALTH DIVISION OF DISEASE CONTROL

SFN 60703 (10-2019)

Requestor's Information		
Last Name:	First Name:	
Date of Birth:	Gender: ☐ Male ☐ Female	
Street address:		
City:	State:	ZIP Code:
☐ **I would like to opt out of the NDIIS.** ☐ **I have previously opted out of the NDIIS but would now like to opt back in.**		
☐ By checking this box and typing my name below, I am signing this document electronically. I agree that my electronic signature is the legal equivalent of my manual/handwritten signature. I agree that the electronic signature appearing on this document has the same validity and enforceability as a handwritten signature.		
Requestor's Signature:		Date:

North Dakota Department of Health *(For Office Use Only)*		
Date Received:	Date Fulfilled:	Initials: