

ORLAND PRIMARY CARE SPECIALISTS, LTD.

**Notification: Opting out of Illinois' Immunization Registry**

I request that my immunization information be removed from the Illinois Immunization Registry. I understand the state will not share immunization data on me from the registry as a result of this action. The registry will retain core demographic information necessary to identify that I have chosen to opt out of the registry. This information is necessary for the registry to be able to filter and refuse entry of immunization information for me. Additionally, any prior immunization records associated with me will not be shared from the registry. No immunization information will be added to the registry for me until the Illinois Immunization Program receives notification that I wish to opt back into the registry.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date of Birth of Patient

\_\_\_\_\_  
Signature of Patient/Representative

\_\_\_\_\_  
Today's Date

AUTHORITY OF REPRESENTATIVE:

I, \_\_\_\_\_, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis:

Relationship to Patient: \_\_\_\_\_

[A signed copy of this permission will be provided to the patient/representative. **Please place a copy of this form in the patient's medical chart.**]