



Wyoming Immunization Registry Rescind Opt-Out Form



Stefan Johansson
Director

Mark Gordon
Governor

The Wyoming Immunization Registry (WyIR) is a confidential, computerized, population-based system that collects and maintains immunization data for Wyoming residents of all ages as reported or submitted by Wyoming immunization healthcare providers. The WyIR includes data analysis tools used by the Wyoming Department of Health, Public Health Division for designing and sustaining effective immunization strategies to prevent disease and reduce healthcare costs. Enrolled healthcare providers are able to report to the WyIR the vaccines that patients have received in the past, as well as, review any recommended vaccines at the time of a healthcare visit. Enrolled healthcare providers may also print immunization records from the WyIR for Wyoming residents. Information in the WyIR may only be used and disclosed as permitted or required by state and federal law, including the HIPAA Privacy Rule.

This request is to rescind a previous request to have your or your child or dependent information opted-out of the WyIR. Rescinding the option to Opt-Out of the WyIR will mean that both patient and immunization information will be reported to the WyIR and will be identifiable in the WyIR moving forward from the time of submission and processing of this request. Historical information from previous vaccination encounters prior to rescinding will need to be added to your record in the WyIR either through submission of the Record Amendment Request to the Wyoming Department of Health, or through your healthcare provider or local Public Health Nursing office, accompanied by proof of immunization.

Patient Information: Please print clearly.

FIRST NAME: _____ MIDDLE NAME: _____

LAST NAME: _____ MAIDEN/OTHER NAME: _____

DATE OF BIRTH: _____ GENDER: FEMALE MALE

STREET ADDRESS: _____

MAILING ADDRESS (If different from Street address): _____

CITY _____ STATE _____ ZIP CODE _____



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By signing this Rescind Opt-Out form, I confirm that I am the individual or parent/legal guardian of the individual listed above. I choose to have immunization information for myself/my child reported to the WyIR.

(Please print) Individual or Parent/Legal Guardian Full Name

Signature of individual or Parent/Legal Guardian

Date

It is your responsibility to mail, fax or email this form to with proof of identity to:
Wyoming Department of Health
Immunization Unit
122 West 25th Street, 3rd Floor West
Cheyenne, WY 82002
Fax 307-777-3615
Email: wyir@wyo.gov
If you have questions, call 307-777-7952 or email wyir@wyo.gov.

For Office Use Only

Date Received: _____

Approved _____ Denied _____

Delayed, we will act on this request by: _____

Comments: _____

WDH Representative Signature: _____