COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

Authorization/Request for Exclusion from
Pennsylvania Statewide Immunization Information System (PA SIIS)

I hereby authorize and request the Pennsylvania Department of Health to exclude from the PA SIIS information contained therein on immunization treatment and services provided to the person named in Section 1 below (hereby referred to as "patient"). Fields marked with * are required.

Section 1 – Patient Information

First Name*: _____

Middle Name*: _____

Last Name*: _____

Date of Birth (MM/DD/YYYY)*: _____

Street Address*: _____

Address Line 2: _____

City*: _____

State*: _____

Zip Code*: _____

Section 2 – Parent/Guardian Information (complete ONLY if patient is under the age of 18)

☐ Patient is under the age of 18

Relationship to patient (enter "Parent" OR "Guardian")*:_____

Parent/Guardian First Name*: _____

Parent/Guardian Last Name*: _____

Section 3 – Signed by Authorized Person

If the patient is 18 years or older, the patient is the Authorized Person.
If the patient is under the age of 18, the Parent/Guardian named in Section 2 is the Authorized Person.

Print Name*: _____

Signature*: _____

Date*: _____