DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-05102 (Rev. 7/2019)

STATE OF WISCONSIN
Wis. Stats. Chapter 252.04

WISCONSIN IMMUNIZATION REGISTRY OPT-OUT REQUEST

Completion and filing of this form is voluntary.

The Wisconsin Immunization Registry (WIR) is a confidential, web-based database that collects and consolidates vaccination data for Wisconsin residents of all ages, and provides tools for designing and sustaining effective immunization strategies to prevent disease, and reduce healthcare costs. By accessing the secure WIR web application, your healthcare provider will be able to see the immunizations that you/your child have received even if you forget to bring the records to the clinic.

Choosing to opt-out of participation in the WIR, for yourself, or your child, means that the demographic and immunization information is locked so it is not available to any WIR users or to the individual themselves.

You have the right to elect to opt back in; this request can be done by filling out form (F-02487), which is available on the DHS website or from the WIR Help Desk at 608-266-9691. This Opt-out form will be maintained with the Wisconsin Department of Health Services, WIR. WIR must receive a completed Opt-out request before the record is locked in the WIR.

Print name of person whose record will be locked.

First Name	Middle	Last	Maiden Name (if applicable)

Date of Birth(MM/DD/YYYY)	Wisconsin County of Birth

Parent's Birth Surname (listed on child's birth certificate)	Parent's Birth Surname (listed on child's birth certificate)

By signing this Opt-out Request, I confirm that I am the individual, or parent/legal guardian of the child named above. I choose to have immunization information for myself/my child excluded from WIR at this time. I understand that I can continue to receive vaccines for myself/child from my healthcare provider even if the immunization information is excluded from WIR.

SIGNATURE – Individual/Parent or Guardian	Date Signed

Print Name of Individual/Parent or Guardian Signing

If additional information is needed to fulfill this request, whom should we contact, provide name and phone number.

Contact Name	Telephone number (include area code)

Please return this completed form to: Wisconsin Immunization Program, P.O. Box 2659, Madison, WI 53701-2659

Official use only	
Date Received	Request fulfilled by