HENRY COUNTY HEALTH DEPARTMENT

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Consent/Authorization for Immunizations and Release of Information

Patient Name: _____ Date of Birth: _____

Consent for Immunizations I have read or had explained to me and have been given the Vaccine Information Statements for the vaccines that are planned to be given. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccines(s) be given to me or the person named for whom I am authorized to make this request.

Consent for Nursing Care/Services I have read or had explained to me the procedure that is planned to be done. (lice check, BP check, pregnancy testing, blood sugar testing, lead testing, HIV testing and/or other lab work). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the procedure that I am requesting to be done to me or the person named for whom I am authorized to make this request.

Consent for Release of Private Health Information I have had the opportunity to read, have been given a copy, or have been offered a copy of the Henry County Health Department's Privacy Practice and I understand my rights related to my health information. This consent is effective unless and until I revoke it in writing. If I refuse to sign this consent, the Henry County Health Department has the right to refuse to treat me.

Authorization By signing this authorization form, I authorize the use/or disclosure of my health information in the manner described below. I understand that I am under no obligation to sign this authorization form and that the Henry County Health Department who I am authorizing to use and/or disclose my information may not base treatment, payment, or enrollment for health care benefits on my decision to sign this authorization. I have signed this form voluntarily in order to document my wishes regarding the use and/or disclosure of the health information described below. I authorize my immunization record to be disclosed to schools, Help Me Grow, CMH, WIC, other health departments, immunization registry databases, health care providers and others as named: _____.

I understand that if any of these organizations are not a health care provider, health plan or a health care clearinghouse subject to federal privacy standards, the health information disclosed in this authorization may no longer be protected by the federal privacy standards and such organizations may redisclose my health information without obtaining my authorization. Your rights with respect to authorization include (1) the right to revoke or restrict the authorization, in writing at any time except to the extent that we have already taken certain actions based on the authorization prior to revoking it, (2) the right to inspect or copy the health information to be used or disclosed, (3) the right to receive a copy of this authorization. I have had an opportunity to review and understand the contents of this authorization form. By signing this form, I am confirming that it accurately reflects my wishes. This authorization will expire at age 21 or 10 years from today whichever date comes later.

By signing this document, I acknowledge I have had the opportunity to read, have been given a copy, or have been offered a copy of the Notice of Privacy Practice and I am:

- Giving my Permission to receive immunizations
- Giving my Consent for the release of health information related to immunizations
- Giving my Authorization for the release of health information related to immunizations

_____ _____
Patient/Guardian Signature (Health Care Power of Attorney) Date

Insurance Information

☐ I/We HAVE Medicaid	☐ I/We DO NOT HAVE Private Health Insurance or Medicaid
☐ I/We HAVE Private Health Insurance By checking this box, I give my permission to bill my insurance for services that I/my child receive, and that I am liable for any co-pay or deductible imposed by, or charges not covered by my policy. I understand that the coverage and contracted services are uniquely applicable between me and my insurance company, who may or may not cover some services.	
☐ I/We have Health Insurance, but I/we **DO NOT** give permission to bill my insurance provider and will self-pay for all services provided to me/my child.	

By signing below, I attest that all information on this form is accurate, and I am responsible for all costs incurred at the time services are rendered.

_____ _____
Patient Signature/Guardian (Health Care Power of Attorney) Date

_____ _____
Witness Date

2/2024