Flu Clinic Consent Form 2020/2021

Patient Name:___________________________________ Date of Birth:__________ Male/Female

Allergies:____

Patient Name:___________________________________ Date of Birth:__________ Male/Female

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Allergies:____

Patient Name:___________________________________ Date of Birth:__________ Male/Female

Allergies:____

Address:____

Phone:___________________________ Email:____

PAYMENT OPTIONS: ❐ CASH ❐ CHECK RECEIPT# :_______
❐ INSURANCE (Complete information below and have card ready.)

____
Guarantor Full Name **Guarantor Social Security Number** **Guarantor DOB**

____
Primary Insurance **Policy Number** **Group Number**

____
Secondary Insurance **Policy Number** **Group Number**

--**For Nurse Use Only**--

Vaccine USIIS/CVX #	Product & Info	Lot # & Expiration	CPT Billing Code	Dose in mls	Injection Site
☐ **PVT** 158	**FluLaval:** Ages 6 months and up PFS		90471	0.5	IM Deltoid or Anterior thigh R / L
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Nurse Signature____Date_________________________

Uintah County
133 South 500 East
Vernal, UT 84078
(435) 247-1177

Duchesne County
409 South 200 East
Roosevelt, UT 84066
(435) 722-6300

Jordan D. Mathis, M.O.L
Director/Health Officer
T R I C O U N T Y H E A L T H . C O M

HIPAA RELEASE/TERMS & CONDITIONS

- I certify that the information I have provided is true and accurate.
- I have received a copy and have had the opportunity to read, or had explained to me, the information contained in the Vaccine Information Statement(s) about the disease(s) and vaccine(s). I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on the statement be given to me or the person for whom I am authorized to make this request.
- I have been provided the opportunity to read TCHD's Notice of Privacy Practices and have this policy explained to me. In addition, I understand that I may request a copy of these practices in a reasonable alternative format. I agree that this information may be included in a centralized, statewide database and can be shared with schools, daycare centers, health care providers, and other health care professionals as necessary to verify immunizations status, audits, and public health studies. In addition, I agree that this information may be shared with health care personnel or public health personnel who have a legitimate need to have access to the information in order to assist a patient or to protect the health of others closely associated with the patient. I understand that I have the right to revoke this authorization at any time by notifying TCHD in writing. I understand that once my data is shared with another individual or agency that it may lose the protections provided by the Privacy Rule, and may be subject to redisclosure by the recipient.
- As a courtesy, we will bill your insurance/Medicaid. By signing you give us permission to bill Insurance/Medicaid and acknowledge that anything not covered will be your responsibility.

Print Name Authorized Signature Date

Print Name Authorized Signature Date

I,_____ hereby grant permission for my family and or I to participate and appear in video and or photographs, websites, social media sites for the purpose of promotion of TriCounty Health Department.