CRAWFORD COUNTY PUBLIC HEALTH

PREVENT • PROMOTE • PROTECT

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CLIENT IMMUNIZATION AUTHORIZATION/INSURANCE AUTHORIZATION/HIPAA

I, _____ the undersigned parent/legal guardian/person
(Parent/Guardian's Full Name)
Having legal custody of_____ _____
(Please Print Full Name of Child) & (Date of Birth)
Provide consent to the appropriate licensed health care provider of the Crawford County Public Health to proceed with the administration of the appropriate vaccines based on age and the schedule recommended by the Ohio Department of Health for my child, a minor, noted above. I understand that the Immunization Guidelines followed by the Crawford County Public Health staff are the same as recommended by the Ohio Department of Health and the American Academy of Pediatrics.

****Please send the child's shot record and insurance card along to the appointment****

Yes	No	Has the above named child:
		Had convulsions or seizures?
		Had a severe reaction to any vaccine, eggs, medications, or gelatin?
		Had cancer, leukemia, AIDS, or any other immune system problem, or have they taken cortisone, prednisone, other steroids, anticancer drugs or x-ray treatments in the last 3 months?
		Sick today?
		Pregnant or at the risk of becoming pregnant in the next month?
		Had blood, plasma, or immune (gamma) globulin transfusion in the last six months:

PLEASE PROVIDE ADDITIONAL INFORMATION ON ANY YES ANSWERS

Vaccination Name:	**Notes:**	**Yes, I want my child to receive this vaccine today**
Tdap	Required for grade 7	
Meningitis(MenACWY)	Required for grades 7 &12	
Meningitis B	Available for persons 16-26yo (full vaccination requires 2 doses	
Hepatitis A	Full vaccination requires 2 doses	
Hepatitis B	Full vaccination requires 2 doses	
Chickenpox	Full vaccination requires 2 doses	
Gardasil	Full vaccination requires 3 doses	

IMMUNIZATIONS: I have received & read or have had read to me, the information contained in the Vaccine Information Statement(s) (VIS) about the vaccines to be received. I've had the chance to ask questions & these were answered to my satisfaction. I understand the benefits/risks of the vaccines to be received. I allow for release of this record to medical providers/health depts./schools/daycare centers/others as may be necessary. I understand this information is being sent to a central registry at the Ohio Dept. of Health.

For current VIS Sheets, please visit
https://www.cdc.gov/vaccines/hcp/vis/current-vis.html

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If someone accompanies the child other than the parent of guardian
THIS SECTION MUST BE COMPLETED:

I do hereby authorize _____ to represent me
(Please print name of adult bringing child to clinic)

Adult bringing child to clinic Signature: _____Date____/____/____

CONSENT FOR ASSIGNMENT OF BENEFITS: I consent to assign all insurance payments for the services given today to Crawford County Public Health and understand that I am responsible for all co-payments, deductibles, and other amounts not covered by my insurance.

Patient Name: _____Birth Date:_____

Choice #1 Bill Insurance

○ I authorize CCPH to submit to patient's insurance (Please provide the patient's private insurance, Medicaid, or Medicare card to the clerk to copy)

Choice #2 Patient/guarantor will self-pay for all services & fees.

○ The Patient **does not** have private insurance or Medicaid/Medicare coverage. (Children without insurance coverage are eligible for reduced cost under the VFC program)

○ The Patient has insurance but the vaccine or service is not covered by the insurance

○ Crawford County Public Health is a non-participating provider with the patient's health insurance.

○ I **do not** give permission for the patient's insurance agency to be billed for services.

Notice of Privacy Practices: CCPH provides information about how we may use and disclose protected health information about you. The notice also contains a patient rights section describing your patient rights under the law. You have a right to review this notice before signing this consent. CCPH provides this form to comply with the Health Insurance Portability and Accountability Act of 1996(HIPAA).

I give my consent to CCPH to use and disclose my protected health information for the purpose of treatment, payment and operations of my health care and this clinic. I understand that I have the right to revoke this consent in writing at any time. However, such a revocation shall not affect any disclosures CCPH has already made in reliance on my prior consent. I understand that I have the right to request a restriction or limitation on the medical information CCPH uses or discloses about me for treatment, payment or health care operation. This request must also be done in writing and I understand that whenever possible CCPH will honor my request.

Specifically I authorize:

1. CCPH to give my information to the identified insurance carrier(s) for any and all payment activities.
2. CCPH to conduct, plan and direct my treatment and follow-up among multiple health care providers who may be involved in that treatment directly or indirectly.

I have had a chance to review the Privacy Notice as part of the registration process. I understand that the terms of the Privacy Notice may change and I may get those changed notices by contacting CCPH by phone or in writing

Parent/Guardian/Adult signatures are in recognition & acceptance of content of this page.

Parent/Guardian Signature_____ Date_____/_____/_____

Address:_____ Phone: _____