

# Consent/Authorization for Immunizations and Release of Information

Henry County Health Department  
1843 Oakwood Avenue  
Napoleon Ohio 43545  
419-599-5545

Patient Name: \_\_\_\_\_

## **Consent for Immunizations**

I have read or had explained to me 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 Release of Private Health Information**

By signing this consent, I authorize the use and/or disclosure of my health information for (1) treatment, (2) payment or (3) health care operations. I have the right not to sign this consent; however, if I refuse to sign this consent, the Henry County Health Department has the right to refuse to treat me.

My rights with respect to consent include; (1) to receive a paper copy of our Notice of Privacy Practices prior to signing the consent, (2) to request restrictions on the uses and disclosures of health information, (3) the right to revoke the consent at anytime except to the extent that we have already taken certain actions based on the consent prior to revoking it, (4) the right to receive a copy of this consent form after you sign it.

This consent is effective unless and until I revoke it in writing.

## **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, 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 anytime 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 received 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 Signature (Guardian or Health Care Power of Attorney)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date