Clinton County Health District

Public Health - Prevent. Promote. Protect.

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Immunization Consent

I have received a copy and have read or had read to me and explained the information contained in the vaccine information statement. I have had a chance to ask questions which were answered to my satisfaction. I understand the risks and benefits of vaccine(s) and I authorize that the vaccine(s) be given to me or the minor for whom I am authorized to make this request. I give permission to release immunization information records for the Ohio Department of Health Immunization registry. I understand that it is recommended to wait at the clinic seated for 15 minutes following the vaccination.

Financial Policy Acknowledgement

By signing this consent, I acknowledge that I have been offered a copy of the financial policy. I understand and agree with the financial policy. I also require payment of government benefits and/or Health insurance to go to the Clinton County Health Department.

HIPPA Acknowledgement

By signing this consent, I acknowledge that I have received the notice of Privacy Practices. I authorize the use and/or disclosure of my health information for treatment, payment, or healthcare operations. I have the right to not sign this consent. However, if I refuse to sign this consent the Health Department has the right to refuse treatment to me. My rights include (1) to receive a paper copy of the notice of privacy practices prior to signing consent (2) to request restrictions on the uses and disclosures of health information, (3) the right to revoke the consent at any time except to the extent the Health Department has already taken based on the consent prior to revoking it, (4) the right to receive a warning of the consent form after it is signed. This consent is effective unless and until I revoke it in writing.

Signature:_____ Date:_____

Printed Name:_____

Relationship to Patient (If not Patient) :_____