Knox PUBLIC HEALTH

School Immunization Consent Form

Patient Name: _____ **Patient Date of Birth:** _____

ALL PATIENTS:
I give my consent for the Knox County Community Health Center (KCCHC) to provide treatment. _____ (Initial)

RELEASE/SHARING OF INFORMATION
I authorize the KCCHC to **release** and **obtain** verbal, written and electronic health information about the above-named client to and from health care providers involved in the medical and/or dental treatment and management of the client's medical or dental care and with specialists we may refer to.

I authorize release of all health information except: _____

I understand that these records are protected under federal and state laws and regulations and cannot be disclosed without my written consent unless otherwise provided by law.

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment, or other healthcare operations. This is a voluntary agreement. You may opt- out at any time by notifying the office administrator.

I authorize the KCCHC to release any information from my medical/dental records to medical assistance, Medicaid, Medicare, other governmental payers, private insurance companies or plans or organizations acting on their behalf, as may be necessary to determine benefits and process claims and others involved in the collection of accounts.

I understand as condition of receiving care with KCCHC, KCCHC may use or disclose my personally identified health information for such treatment, payment and health care operation purposes. These uses and disclosures are more fully explained in the *Notice of Privacy Practices* that has been made available to me and I have reviewed.

I understand the privacy practices described in the *Notice of Privacy Practices* may change over time and that I have a right to obtain any revised *Privacy Notice* by contacting the Knox County Community Health Center to make a request. KCCHC is located at 11660 Upper Gilchrist Road, Mount Vernon, Ohio 43050.

I understand I have the right to revoke/withdraw this consent, in writing, at any time. My revocation will be effective except to the extent KCCHC has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

I authorize release of my medical information necessary to process the claim. I also authorize payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.

I have received an explanation of the risks and benefits for all services received and my questions have been answered. I also understand I have the right to refuse services at any time. If I refuse services, KCCHC will make efforts to ensure that I understand the implication and potential consequences of refusing or withdrawing consent for services

Who may we discuss and share your health records with during this Annual Consent period?

I give KCCHC authorization to share my health records with:

Name: _____ *Phone:* _____

Name: _____ *Phone:* _____

Signature of Patient (If patient is a minor parent or guardian):_____ **Date**_____

If Minor Relationship to Patient:_____ **Date**_____

Witness Signature: _____ **Date** _____

Knox PUBLIC HEALTH

School Immunization Demographics Form

Patient Information: ***Today's Date:*** _____

Last Name: _____First Name: _____ MI:_____

Any other name patient may have gone by in past: _____ Date of Birth: _____

Address: _____ City: _____ Zip Code: _____

County: _____ SS#_____-_____-_____ Home Phone: _____-_____-_____ Cell Phone: _____-_____-____

How do you prefer to be reminded of your appointment ☐ Text ☐ Call Email Address:_____

Gender at birth: ◯Male ◯Female ◯Other

By providing email address you are acknowledging authorization to send correspondence by this medium.

Currently Gender Identity: ◯ Male ◯Female ◯Transgender Male ◯Transgender Female ◯Don't Know ◯Other: _____

Race: ◯White ◯African American ◯Asian ◯Other:_____ ◯Choose not to disclose

Ethnicity: ◯Hispanic or Latino ◯NOT Hispanic or Latino ◯Unknown or Choose not to disclose

Complete if Patient is a Minor:

For all minor patients (under 18 years of age), legal guardians will be asked to show documentation to prove that a legal relationship exists. This is for both the safety of the child and guardian and to ensure that the legally appointed parent or guardian is responsible for making medical decisions on behalf of the minor. **Applicable legal documents pertaining to custody, divorce, separation, adoption or name change of parent or child are required.**

Parent/Guardian Name:_____ Relationship to Patient: _____

Current Custody Status: ☐ Parents ☐ Sole Parental Custody ☐ Joint Legal Custody ☐ DSS Custody ☐ Other:

Emergency Contact:

Last Name: _____ **First Name:_____**

Relationship to Patient:_____ **Emergency Contact Telephone Number:_____**

Responsible Party: ***Complete ONLY if Patient is 18 years old or younger, attending school, or has a legal guardian***

Last Name: _____ **First Name:_____**

Relationship to Patient:_____ **Responsible Party Telephone Number: _____**

Mailing Address (If different from patient):_____

Primary Insurance:	**Secondary Insurance:**
Insurance Company _____	Insurance Company _____
Participant' Name _____	Participant' Name _____
Participant's DOB _____	Participant's DOB _____
Participant's Relationship to Patient _____	Participant's Relationship to Patient _____
Participant's ID # or SS#_____	Participant's ID # or SS#_____

TO BE FILLED OUT IN the OFFICE

Tdap	*Lot #*	*Site:*	*Dtap/IPV*	*Lot #*	*Site*
Meng	*Lot #*	*Site:*	*MMR/Varicell*	*Lot#*	*Site*
Other	*Lot#*	*Site:*	*Other*	*Lot#*	*Site*

ADMINISTERED BY: *DATE:*