COVID-19 Vaccine Consent Form
HEALTH CARE PHARMACY, INC
1030 PRESIDENT AVENUE
FALL RIVER, MA 02720

VACCINE RECIPIENT INFORMATION

Last Name | First Name | Date of Birth | Gender

Address | City | State | Zip

Primary Phone Number | Primary Care Physician (PCP) | PCP Phone

INSURANCE INFORMATION

Plan Name | RX BIN | RX PCN | Cardholder ID | RX Group

Medicare A/B ID Number

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. **AUTHORIZATION TO REQUEST PAYMENT:** I do hereby authorize Health Care Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all record to act on this request. I request that payment of authorized benefits be made on my behalf. **DISCLOSURE OF RECORDS:** I understand that Health Care Pharmacy may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at HCP (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment, or other health care operations. I also understand that HCP will use and disclose my health information as set forth in the HCP Notice of Privacy Practices (copy available in-store or by requesting a paper copy from the pharmacy). Vaccine clinics: If I am receiving a vaccine through a vaccine clinic, I understand that my name, vaccine appointment date and time will be provided to the clinical coordinator.

Signature of patient to receive vaccine (or parent, guardian, or authorized representative) | Date

Name of parent, guardian, or authorized representative | Phone Number | Relationship

VACCINE ADMINISTRATION INFORMATION (for Immunizer/Pharmacist use only)

COVID-19

Administration Date | Vaccine | VIS Date | Manufacturer | Volume (ml)

IM

Lot # | Exp. Date | Route | Site | Patient Temperature

Administering Immunizer Name & Title | Administering Immunizer Signature