CONSENT TO COVID-19 VACCINATION

The County of Santa Clara is offering COVID-19 vaccination to individuals who meet the Centers for Disease Control (CDC) and California Department of Public Health (CDPH) criteria for vaccination, regardless of insurance or ability to pay. There is no cost to you for vaccination, and insurance is not required. However, if you have health insurance that covers this service, your insurance may be billed.

CONSENT

I have been provided with and have read or have had explained to me the Emergency Use Authorization Fact Sheet for the COVID-19 vaccine that I am receiving and I have had an opportunity to ask questions, which have been answered to my satisfaction. I understand the risks and benefits of receiving the COVID-19 vaccine and request that the vaccine be given to me or to the person for whom I am the legal representative authorized to make this request. I understand that my vaccination will be entered into the local California Immunization Registry (CAIR), which will allow for coordinated care between my health care providers.

ASSIGNMENT OF INSURANCE/MEDICAL BENEFITS

I irrevocably assign and transfer to the county all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the county of all insurance and health plan benefits payable for this outpatient service, at a rate not to exceed the charges listed in the charge description masters. I agree that the insurer or plan’s payment to the county pursuant to this authorization shall discharge its obligations to the extent of such payment. I agree to cooperate with, and take all steps reasonably requested by, the County to perfect, confirm, or validate this assignment.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the Notice of Privacy Practices (NPP) of the County of Santa Clara Health System (CSCHS). Our NPP gives you information about how we may use and disclose your medical or protected health information (PHI). Our NPP is subject to change. If we change our notice, we will post the revised version in our facilities and on our website here: https://www.scvmc.org/patients-and-visitors/services/Documents/Notice%20of%20Privacy%20Practices%20-%20Mar%202019%20final.pdf

I certify that I am the patient, the patient’s legal representative, or otherwise authorized by the patient to sign the above and accept its terms on the patient’s behalf.

Signature (patient or legal representative):

Patient Name: ____________________________ Date: ______________

Parent/Guardian printed name (if applicable): __________________________

If not patient, indicate relationship to patient: __________________________

Modern EUA Fact Sheet
(Paper copy available upon request)

Pfizer EUA Fact Sheet
(Paper copy available upon request)

Johnson & Johnson EUA Fact Sheet
(Paper copy available upon request)