Conditions of Treatment

Please read and initial each item below:

_____ **Consent for Treatment**
I have received a copy and have read, or had explained to me, the information contained in the Vaccine Information Statement(s) about the vaccine(s) I have requested or have been recommended to me, their risks, and about the disease(s) that the vaccine(s) protect against. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated in the Vaccine Information Statements stated above be given to me or to the person for whom I am authorized to make this request. I certify that these statements are true and accurate.

_____ **Insurance Coverage**
Applies only if billing Medicaid, Medicare, and/or a Salt Lake County Health Department-contracted insurance

I understand that my health insurance coverage may have certain restrictions and limitations. I agree to pay the full amount for any and all related charges, if they are not covered by my insurance. If I fail to pay for these services and charges within sixty (60) days or receiving notice that the charges are not covered for any reason, my account will be turned over to collections. In the event my account is turned over to collections, I agree to pay attorney fees and collection charges which may apply. I hereby request and authorize the Salt Lake County Health Department to submit claims to my Medicaid, Medicare and/or Health Department-contracted insurance.

_____ **Privacy Rights**
I have been provided and have had the opportunity to read Salt Lake County Health Department's Notice of Privacy Practices. Furthermore, any questions I had regarding the policy have been explained to me by the Health Department staff. In addition, I understand that I may request a copy of these practices in a reasonable alternative format. I agree that this information may be shared with health care providers, health care personnel, public health personnel and other health care professionals who have a legitimate need to access the immunization information to: verify immunization status; audits; conduct public health studies; and assist a patient or to protect the health of individuals closely associated with the patient. I understand that I have the right to revoke this authorization at any time by notifying the Salt Lake County Health Department in writing. This release of information will be effective until canceled in writing. I understand that once my data is shared with another individual or agency, it may lose the protections provided by the HIPAA Privacy Rule, and may be re-disclosed by that recipient. I understand that I may decline to agree to the terms in this paragraph by requesting and signing the Health Department's PHI Sharing Declination Form.

SALT LAKE COUNTY HEALTH DEPARTMENT

Conditions of Treatment

Approval of Information Release

I authorize the following people to have access to my medial and financial information, unless I specify otherwise. This means that the providers and staff at Salt Lake County Health Department can discuss medical conditions, treatments, insurance coverage, and fees/payments with the following individuals.

Name: _____ Relation: _____

Name: _____ Relation: _____

☐ Declined; do not discuss my information with anyone

Initial Here: _____

Indicate relationship to the person receiving treatment:

☐ Self ☐ Parent ☐ Sibling (over 18) ☐ Grandparent

☐ Guardian ☐ Other: _____

If under 18 years of age:

I am a:

☐ Pregnant Minor ☐ Married Minor ☐ Homeless Teen

By signing, you indicate that you have read, understand, and agree to these terms; that you have received a copy of this document; and that you are the patient, guarantor, the patient's legal representative, or legally authorized to sign this agreement and accept these terms. By signing, you also consent to treatment as outlined above.

Patient Name (please print): _____

Your Name (please print): _____

Signature: _____ Date: _____