



Clermont County Public Health

Prevent. Promote. Protect.

Immunization Consent

I have received a copy and have read or have 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 benefits and risks of the vaccine(s) and I authorize that the vaccine(s) given to me or the minor for whom I am authorized to make this request. I give permission to release the immunization record to the Ohio Department of Health immunization registry. I understand that it is recommended to wait at the clinic sit for 15 minutes following vaccination.

Patient Signature (Parent or Guardian)

Financial Policy Acknowledgment

By signing this consent, I acknowledge that I have received a copy of the Financial Policy. I understand and agree with the Financial Policy. I also request payment of government benefits and/or health insurance to the Clermont County General Health District.

Patient Signature (Parent or Guardian)

HIPPA Acknowledgment

By signing this consent, I acknowledge that I have received the Notice of Privacy Practices.

authorize the use and/or disclosure of my health information for treatment, payment, or health care operations. I have the right not to 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 that the Health Department has already taken certain actions based on the consent prior to revoking it, (4) the right to receive a copy of this consent form after it is signed. This consent is effective unless and until I revoke it in writing.

Parent Signature (Parent or Guardian)

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An Accredited Public Health Agency