Indiana Department of Health

Eric J. Holcomb
Governor

Kristina M. Box, MD, FACOG
State Health Commissioner

PATIENT CONSENT FOR COVID-19 VACCINATION

Explanation of Vaccination:

Vaccination for SARS COVID-19 is an intramuscular injection. Intramuscular injections are administered at a 90 degree angle to the skin, preferably into the deltoid muscle of the upper arm. Risks associated with this vaccination include mild side effects, such as fever, injection site pain, headache, muscle aches and fatigue, and a small percentage may still be vulnerable even after receiving the vaccine. This vaccine will require two (2) doses to work, and you will need to return for the second dose within the recommended time frame. This vaccine is presently available under an Emergency Use Authorization (EUA) issued by the U.S. Food and Drug Administration (FDA).

PATIENT'S CONSENT

I, the undersigned, certify that I am at least eighteen (18) years of age, have been informed about the vaccine purpose, procedure, and risks, and I have elected to receive. I understand this vaccination may be subject to reporting to a health information exchange or an immunization registry, who may share my vaccination information with others, and to my health care providers, for treatment purposes or as otherwise permitted by law. I have had the opportunity to have all my questions addressed before receiving the vaccine. I voluntarily consent and agree to receive the vaccination for COVID-19.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION:

I authorize the Indiana State Department of Health to disclose protected health information about me to my employer as described below:

Description of Information to be released: COVID-19 Vaccination Results

Purpose of Release: To ensure patient receives documentation of the COVID-19 vaccination.

Use and disclosure may be withdrawn: AUTHORIZATION: I understand that once the authorized information has been disclosed, it may not longer be protected by the HIPAA Privacy Rule. I understand that the covered entity seeking this authorization may not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on whether I sign the authorization. I may revoke this authorization at any time, in writing,

except to the extent that action has been taken in reliance on this request. Written revocation will be effective upon receipt by the Indiana State Department of Health at 2 N. Meridian St., Indianapolis, IN 46204. Without my express revocation, this request will automatically expire one hundred and eighty (180) days after the date of signature.