888-385-4555 info@vaxonsite.com PO BOX 1166 Odessa, FL 33556

NPI # 1982152054

# Authorization Consent Form for Vaccinations 2024-2025

**PRINT NAME** _____ ____ _____ **Birth Date**_____
First M. Last

**Address** _____

_____ _____ _____
*City* *State* *Zip Code*

**Phone** _____ ○ **Male** ○ **Female** **Location of on-site clinic** _____

**Medicare Number (11 digits)** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **Or**

**Primary Insurance Company Name** (Medicare Adv, HMO, PPO, POS etc.) _____

**MEMBER ID #** _____ **GROUP #**_____

**Place an X in the circle for the vaccine(s) you want to receive. We will discuss all vaccinations prior to administration.**

○ **FLU age 65+** ○ **FLU age 8+** ○ **COVID-19 (latest)** ○ **PNEUMONIA (New Prevnar20)**

○ **B12 shot $20**. ○ **B12 LIPO shot (Fat Burner) $25.**

***Vaxonsite, LLC cannot accept Medicaid. Those insured by Medicaid must see their primary care physician***

**I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, mobile clinic, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree that I am responsible for payment in full to Vaxonsite, LLC for any limitations described above.**

**CONSENT FOR SERVICES, MEDICAL RECORDS and HIPAA PRIVACY INFORMATION**

I have been provided with the Vaccine Information Sheet corresponding to the vaccine(s) that I am receiving. I have read or have been explained 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 the vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I voluntarily authorize and direct my health care provider at Vaxonsite to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated by Vaxonsite, my Primary Care Physician (PCP), my insurance plan and/or state or federal registries, where required, for purposes of treatment, payment, or other health care operations (such as administration or quality assurance). This authorization permits Vaxonsite to disclose the following medical records: only documents related to the vaccination(s) received today. This Authorization will remain in effect until my health care provider discloses my health information to the recipient identified above; my health care provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such a refusal or revocation will not affect the commencement, continuation, or quality of my treatment by my health care provider. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation. I acknowledge that I have received the Vaxonsite Notice of Privacy Practices, which is provided at www.vaxonsite.com and at the clinic. Medicare Billing: I do hereby authorize Vaxonsite to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

⇨ **PATIENT SIGNATURE / POA**_____ **DATE** _____

**This section to be completed by Vaxonsite RN or Physician:**

Date_____ Product_____ Site_____ Lot #_____ _____Exp. Date_____

Date_____ Product_____ Site_____ Lot #_____ _____Exp. Date_____

Administering Immunizer Name & Title _____