Jackson County Health Dept.
1715 Lansing Ave., Suite 221, Jackson, MI 49202
Phone: 517-788-4420
www.mijackson.org/hd

Immunization Consent

I have been given a copy and have read, or have had explained to me, the information contained in the Vaccine Information Sheet or the appropriate important information about the disease(s) and the vaccine(s) which are to be administered today. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s).

I ask that the vaccine(s) I have requested be given to me, or to the person named for whom I am authorized to make this request, and I ask that the administration of the vaccine(s) be recorded by the Jackson County Health Department. I am also aware that this information may be shared with my physician and local and State immunization registries.
I understand that it is my responsibility to know my insurance coverage limits. Further I understand that the Jackson County Health Department may bill my insurance for the vaccine(s) administered and it is my responsibility to pay for any fees not covered by my insurance.
I understand that for the safety of the vaccine, I need to wait 15 minutes after administration before leaving the site of vaccination.

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.
The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment and healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.
By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The Health Department reserves the right to change the privacy policy as allowed by law.
- The client has the right to revoke his/her consent in writing at any time and all full disclosures will then cease.
- The health department may condition receipt of treatment upon execution of this request.