



CONSENT TO COVID-19 VACCINATION

The County of Santa Clara is offering COVID-19 vaccination to individuals who meet State of California criteria for vaccination. There is no cost to you for vaccination and insurance is not required. However, if you have health insurance that covers this service, your insurance may be billed.

CONSENT

I have been provided with and have read or had explained to me the Fact Sheet for the COVID-19 vaccine that I am receiving (or if legal representative, the person I am representing is receiving). I have had an opportunity to ask questions, which have been answered to my satisfaction. I understand the risks and benefits of receiving the COVID-19 vaccine and request that the vaccine be given to me / the person for whom I am the legal representative. I understand that my vaccination will be entered into the local California Immunization Registry (CAIR), which will allow for coordinated care between my health care providers.

ASSIGNMENT OF INSURANCE/MEDICAL BENEFITS

I irrevocably assign and transfer to the County all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment includes assigning and authorizing direct payment to the County of all insurance and health plan benefits payable for this outpatient service, at a rate not to exceed the charges listed in the charge description masters. I agree that the insurer or plan's payment to the County pursuant to this authorization shall discharge its obligations to the extent of such payment. I agree to cooperate with, and take all steps reasonably requested by, the County to perfect, confirm, or validate this assignment.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the *Notice of Privacy Practices (NPP)* of the County of Santa Clara Health System. Our NPP gives you information about how we may use and disclose your medical or protected health information. Our NPP is subject to change. If we change our notice, we will post the revised version in our facilities and on our website here: <https://www.scvmc.org/sites/g/files/exjcpb911/files/Notice%20of%20Privacy%20Practices%20-%20English%20Mar%202019%20final.pdf>

SUBSEQUENT DOSE ACKNOWLEDGEMENT FOR PFIZER AND MODERNA VACCINE

I agree that once I receive a first dose of Pfizer or Moderna vaccine I will need to schedule a subsequent vaccine dose(s). I consent to receive email or text messages with reminders about my COVID-19 vaccine appointment if I have not yet received my subsequent vaccine dose(s). I understand that such messages will not be sent securely.

I certify that I am the patient, the patient's legal representative, or otherwise authorized by the patient to sign the above and accept its terms on the patient's behalf.

Signature (*patient or legal representative*): _____

Patient Name: _____ Date: _____

Parent/Guardian printed name (if applicable): _____

If not patient, indicate relationship to patient: _____

**Moderna
Fact Sheet**
(Paper copy
upon request)



**Moderna 6mos-5yrs
Fact Sheet**
(Paper copy
upon request)



**Pfizer
Fact Sheet**
(Paper copy
upon request)



**Pfizer 5-11
Fact Sheet**
(Paper copy
upon request)



**Pfizer 6mos-4yrs
Fact Sheet**
(Paper copy
upon request)



**Johnson & Johnson
Fact Sheet**
(Paper copy
upon request)

