Health & Human Services Department
2100 Ridge Avenue
Evanston, IL 60201
847-448-4311

City of Evanston COVID-19 Consent Form for a Minor

Please visit the following website or scan the QR code to read the Emergency Use Authorization for the Pfizer COVID-19 Vaccine:

https://www.fda.gov/media/144414/download

Please direct specific medical questions to your healthcare provider

If you have general questions regarding the vaccine please email vaccine@cityofevanston.org

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I have read the information provided regarding the specific COVID-19 vaccine being administered. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the COVID-19 vaccine and request it be given to me or to the person named below for whom I am authorized to make the request. I acknowledge that the person receiving this brand of vaccine (Pfizer) is at least 12 years of age.

I acknowledge the receipt of the HIPAA Privacy Notice. I consent to receiving the COVID-19 vaccine. I will report to the health department any severe reaction that I may have from this vaccine. I hereby release, waive, forever discharge, indemnify, hold harmless and covenant not to sue the City of Evanston, is departments, including, but not limited to the Health Department, the City's officials, agents, employees, officers, and representatives from any and all liability for every injury, penalty, claim, loss, cost, damage, demand, cause of action, warranty, either express or implied, controversy, whether known or unknown, whether based in common law, contract, statute, rule or regulation, whether in law or in equity, whether liquidated or unliquidated, all damages, attorney's fees, costs, liens and/or expenses arising out of or related to any loss, damage, or injury, including death, that may be sustained by me as a result of receiving this vaccination. **I acknowledge that it is recommended that I wait at the clinic for at least 15 minutes after receiving the vaccination to assure there are no adverse side effects.**

____
Child's Name

____
Printed Name of Parent/Guardian

____ __________________________
Signature of Parent/Guardian Date

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Notice of Health Info Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and to control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and disclosures of protected Health Information: Your protected health information may be used and disclosed by our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party such as your physician or the local schools. For example, we may disclose your protected health information, as necessary, to a home health agency that provides care to you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining reimbursement from Medicare for flu vaccination.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of the Health Department. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate the visit purpose. We may also call you by name in the waiting room when the healthcare provider professional is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law such as with communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation, research, criminal activity, military activity and national security, worker's compensation, required uses and disclosures. Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction to your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information be restricted to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.