Patient Information

Name:		
Mailing Address:		
City:	State:	Zip Code:
Date of Birth:	Email:	
Cell Phone:	Home Phone:	Is the Patient an American Indian or Alaskan Native? ____ YES ____ NO
Name of Parent or Guardian if applicable (Print):		

Responsible Party or Parent of Minor Child

Parent's Name:		
Date of Birth:		
Cell phone:	Home Phone:	
Parent's Name:		
Date of Birth:		
Cell phone:	Home Phone:	

Insurance Information

Primary Insurance Name:	
Member ID #:	
Group #:	
Policy Holders Name:	
Date of Birth:	Relationship:
Secondary Insurance Name:	
Member ID #:	
Group #:	
Policy Holders Name:	
Date of Birth:	Relationship:

I acknowledge that I have been offered a copy of the Chaffee County Public Health Notice of Privacy Practices.

Signature _____ Date _____

Consent for Public Health Services/ Assignment of Benefits

I have read or have had it explained to me information about the vaccines and/or services to be administered. I have had the opportunity to ask questions that were answeredd to my satisfaction. I belive that I understand the benefits and risks of these vaccines and/or services and ask that they be administered to me ot the the person named previously, for whom I am authorized to make this request. I also acknowledge that I have been offered copies of the appropriate Vaccine Information Statements (VIS) if applicable.

I am aware that I am responsible for all fees for immunizations and services provided to me or for those who are my dependants. I also understand that payment is due at the time of service unless arrangements for insurance billing or private billing are made and authorized by Chaffee County Public Health personnel.

I hereby, authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to Chaffee County Public Health for the medical services rendered to myself, or my dependants. I understand that I am responisible for any amount not covered by insurance.

I hereby authroize Chaffee County Public Health to release any necessary information to insurance carriers needed in order to obtain payment. I am aware that this consent will remain in effect for one full year from the date of signature unless cancelled in

Signature of Patient, Parent, or Guardian _____ Date _____

Signature-Chaffee County Public Health Staff _____

Authorization for Release for Information

_____RELEASE OF INFORMATION ***TO*** CHAFFEE COUNTY PUBLIC HEALTH:

I authorize representatives of Chaffee County Public Health to have access to the requested information of the patient identified below, to the same extent that I have access. I understand that Chaffee County Public Health may use such records and information as further described in their "Notice of Privacy Practices" and acknowledge that I have received a copy of the Notice of Privacy Practices.

_____RELEASE OF INFORMATION ***FROM*** CHAFFEE COUNTY PUBLIC HEALTH:

I authorize representatives of Chaffee County Public Health to release all medical records and information of the patient identified below to the following: (Please provide Name along with address or fax number).

_____

_____

_____

_____

General Provisions:

I hereby release, discharge, and agree to idemnify and hold harmless Chaffee County Pubic Health and its affiliates from any claim, liablility, or cost that may arise by reason of such party relying upon this release.

If the patient is under the age of 18 years old, I represent that I am the parent/legal guardian for the patient idenitfied below.

This authorization shall be valid for one year from the below date unless cancelled in writing.

_____	_____
Print Name of Patient	Date of Birth
_____	_____
Signature of Patient/Parent/Guardian	Date

Chaffee County Public Health

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