FAIRFIELD PHARMACY
66 Western Ave., Fairfield, Maine
Fax 453-6612
453-4411

SARS CoV-2 Moderna Vaccine Consent Form

Location of Clinic:_____ Dose 1 Temp:_____ Dose 2 Temp:_____

Date Given	Lot/Exp Date	Deltoid Location	Route	Immunizer Signature	VIS Date
Dose 1:		R / L	IM		
Dose 2:		R / L	IM		

Complete Questions 1- 9 on the day of each clinic

		Dose 1	Dose 2
1.	Have you received another vaccine in the last 14 days?	Y / N	Y / N
2.	Are you pregnant (or may become pregnant within the coming months) or breastfeeding?	Y / N	Y / N
3.	Do you have a weakened immune system caused by something such as HIV infection or cancer, or do you take immunosuppressive therapies or drugs?	Y / N	Y / N
4.	Are you feeling sick today?	Y / N	Y / N
5.	Do you have a bleeding disorder or are you taking a blood thinner?	Y / N	Y / N
6.	Have you had an adverse reaction to Polysorbate, Polyethylene Glycol (PEG), or a previous vaccination?	Y / N	Y / N
7.	Have you previously tested positive or received treatment for COVID-19?	Y / N	Y / N
8.	I agree to wait in the designated area for 15 minutes after receiving my vaccine, and will seek medical attention for any signs or symptoms of adverse or allergic reactions after receiving this vaccination.	Y / N	Y / N
9.	I understand that if an allergic reaction should occur after being given the vaccine, the pharmacist may administer medications to offset such a reaction	Y / N	Y / N

Complete prior to first vaccination

Patient First/Last Name	Age	DOB	Telephone#
Address	City	State	Zip
Allergies	Primary Care Provider (Name/Number)		
Patient Signature	Date		
Signature (Guardian/POA)	Relationship to Patient	Date	

- **By signing above, I certify that I am a.) over 18 years old and freely and voluntarily give my signed permission to be given both doses of this vaccine, OR b.) the legal guardian/POA for the person listed above and can legally consent for them to be given both doses of this vaccine.**
- **I authorize the release of any medical or other information necessary to process the claim**
- **I also request payment of government benefits to the party who accepts assignment**
- **I acknowledge that I have reviewed the Fairfield Pharmacy Notice of Privacy Practices located on the back of this form, and have been provided with a copy upon request**
- **I agree to hold Fairfield Pharmacy & its staff members harmless from all adverse consequences with respect to the administration of the vaccine**

For billing purposes, please fill out the following information in its entirety and provide a copy of your insurance card. If you do not have insurance coverage, please provide us with your SSN below so that we may collect payment for the vaccine admin fee from the United States' HRSA Covid-19 program.

Insurance Carrier	
Patient ID	
Group #	
Bin #	
PCN #	
Medicare # (if applicable)	
Person Code (Circle One)	Card Holder / Spouse / Child
SSN (uninsured patients only)	

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PHARMACEUTICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our pharmacy is to give our patients this notice (in paper or electronically as the patient wishes) of our legal duties and privacy practices concerning their Protected Health Information, and also to tell our patients about their rights under HIPAA.

I. **Uses and Disclosures of Protected Health Information**. There are two categories for the use and disclosure of our patients' Protected Health Information: (A.) information that we can use and disclose without the patient's prior consent; and (B.) information that we cannot use or disclose without the patient's prior authorization.

A. Patients' Prior Consent Not Required.

1) Treatment. In the first category, we are permitted to use and disclose our patients' Protected Health Information in connection with their medical treatment in situations such as allowing a family member or other relative or a close personal friend or other person involved in the patient's health care to pick up the patient's prescriptions and to receive Protected Health Information that is directly related to the patient's care. In doing so, we are to use our professional judgment and experience with common practice in determining what is in the patient's best interest. Other examples include sending information about a patient's prescriptions to the patient's family doctor or to a specialist who is treating the patient or to a hospital where the patient is receiving care, particularly if the patient has suffered a health emergency.

2) Payment. If a patient is covered by a pharmacy benefit plan, we are entitled to send Protected Health Care Information to the plan or to another business entity involved in our billing system describing the medication or health care equipment we have dispensed so that we can be paid.

3) Health Care Operations. In addition, we can provide Protected Health Information for health care operations such as evaluations of the quality of our patients' health care in order to improve the success of treatment programs. Other examples include reviews of health care professionals, insurance premium rating, legal and auditing functions, and business planning and management.

4) Other Permitted Uses and Disclosures. There are a number of other specified purposes for which we may disclose a patient's Protected Health Information without the patient's prior consent (but with certain restrictions). Examples include public health activities; situations where there may be abuse, neglect or domestic violence; in connection with health oversight activities; in the course of judicial or administrative proceedings; in response to law enforcement inquiries; in the event of death; where organ donations are involved; in support of research studies; where there is a serious threat to health and safety; in cases of military or veterans' activities; where national security is involved; for determinations of medical suitability; for government programs for public benefit; for workers' compensation proceedings; when our records are being audited; when medical emergencies occur; and when we communicate with our patients orally or in writing about refilling prescriptions, about generic drugs that may be appropriate for a patient's treatment, or about alternative therapies.

B. Patients' Prior Authorization Required.

For purposes other than those mentioned above, we are required to ask for our patients' written authorizations before using or disclosing any of their Protected Health Information. If we request an authorization, any of our patients may decline to agree, and if a patient gives us an authorization, the patient has the right to revoke the authorization and by doing so, stop any future uses and disclosures of the patient's health information that the authorization covered. An example of a situation where the patient's prior authorization would be required would be if we wish to conduct a marketing program that would involve the use of Protected Health Information.

II. **Patients' Rights**. HIPAA and the Regulations provide our patients with rights concerning their Protected Health Information. With limited exceptions (which are subject to review) each patient has the right to the following:

1) Patient's Record. Each patient can obtain a copy of his or her Protected Health Information upon written request. The only charge will be based on our cost in responding to the request. The amount of the charge will vary depending on the format the patient requests and whether the patient wants the record or a summary, and whether it is to be delivered by mail or otherwise. The patient will be told of the fee when the patient's request is received. If at the time of the patient's request we maintain an electronic health record with respect to Protected Health Information, the patient has a right to obtain a copy of the patient's Protected Health Information in electronic form and to direct that the copy directed to a clearly identified person or entity.

2) Accounting for Disclosures. Each patient can, upon written request, obtain a list of the disclosures of the patient's Protected Health Information that have occurred within the 6 years preceding the request, except for disclosures made for the purposes of treatment, payment or health care operations and certain others. There will be no charge for the first request in any 12 month period, but we are entitled to charge a reasonable cost based fee for additional requests made in the same period of time. However, if at the time of the patient's request we maintain an electronic health record with respect to Protected Health Information, the foregoing exception will not apply and the period covered for the accounting will be the 3 years preceding the request.

3) Amendments. Each patient may ask to change the record of his or her own Protected Health Information upon written request explaining why the change should be made. We will review the request, but may decline to make the change if in our professional judgment we conclude that the record should not be changed.

4) Communications. Upon written request, each patient can ask us to communicate with him or her about their own Protected Health Information in a confidential manner such as by sending mail to an address other than the home address or using a particular telephone number.

5) Special Restrictions. Upon written request, each patient can ask us to adopt special restrictions that further limit our use and disclosure of the patient's Protected Health Information (except where use and disclosure are required of us by law or in emergency circumstances). We will consider the request; but in accordance with HIPAA we are not required to agree to with the request; provided, however, we will comply with a patient's request to restrict the disclosure of Protected Health Information to a health plan if the disclosure is for payment or health care operations (excluding treatment), and the disclosure pertains solely to a health care item or service for which we have been paid out of pocket in full.

6) Complaints. If a patient believes that we have violated the patient's rights as to the patient's Protected Health Information under HIPAA or if a patient disagrees with a decision we made about access to the patient's Protected Health Information, the patient has the right to file a written complaint with our Contact Person listed below. Our Contact Person is required to investigate, and if possible, to resolve each such complaint, and to advise the patient accordingly. The patient also has the right to send a written complaint to the U.S. Department of Health and Human Services. Under no circumstances will any patient be retaliated against by this pharmacy for filing a complaint.

We are required by law to protect the privacy of our patients' Protected Health Information, to provide this notice about our privacy practices, and follow the privacy practices that are described in this notice. We reserve the right to make changes in our privacy practices that will apply to all the Protected Health Information we maintain. A new notice will be available on request before any significant change is made.

Our Contact Person's Name: Shane Savage R.Ph
Tel. No: 207-453-4411
Fax No: 207-453-6612
Email: gundog37@yahoo.com