Goshen Physicians

Influenza Vaccination Consent & Waiver of Liability

Please Print

Full Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Phone: (_____)_____ E-mail: _____

The following questions will help us determine if there is any reason you should not receive an influenza vaccination today. If you answer *yes* to any question, it does not necessarily mean you should not be vaccinated. We encourage you to ask the clinician questions prior to receiving the influenza vaccine.

YES	NO	
		Have you tested positive for corona virus or have a pending test result?
		Do you have a fever, flu like symptoms, shortness of breath, cough, or recent loss of taste or smell?
		Are you allergic to eggs? (If yes request Flublok)
		Have you ever had a serious reaction to an influenza vaccination?
		Have you ever had Guillain-Barre Syndrome (a severe paralyzing illness)?

I am voluntarily participating in an influenza vaccination program conducted by Goshen Health d/b/a Goshen Physicians. In doing so, I hereby release, discharge, agree and covenant not to sue Goshen Physicians, together with its successors, subsidiaries, officers, employees, representatives and agents of for any claim of liability, of any type whatsoever. This includes, but is not limited to property damage, physical injury, mental anguish, embarrassment, defamation or invasion of privacy, included but not limited to, any claim arising out of, based upon, resulting from or in any way connected to the negligence, omissions, or other acts in which the undersigned may suffer arising out of, based upon, resulting from, or in any way connected to participation in the influenza vaccination program referenced above. This includes the condition or any part of the premises where the above-referenced flu vaccination program is conducted. I understand that information provided by any person associated with Goshen Physicians should not be substituted for regular medical care or advice.

By signing this form, I indicate that I have read and understand this document, including the Goshen Health Notice of Privacy Practices printed on the back of this page. I have been given a copy of the *What You Need to Know* Influenza Vaccine Information Statement (8/6/2021), provided by the Centers for Disease Control and Prevention. I understand the benefits and risks of the vaccination. I have had the opporunity to ask questions, which were answered to my satisfaction. I request that the influenza vaccination be given to me.

X_____ Date: _____

Signature of Person (or Legal Guardian) Receiving Vaccine

FOR GOSHEN PHYSICIANS USE ONLY

Date of Vaccination	Vaccine Manufacturer	Vaccine Lot # and Expiration Date	Site of Injection
		Lot # Expires:	R L Deltoid

X_____

Signature and Title of Vaccine Administrator

NOTICE OF PRIVACY PRACTICES

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.

Uses and Disclosures of Health Information

A. With your consent, we may use health information about you for treatment (such as sending your medical record information to a specialist physician as part of a referral), to obtain payment for treatment (such as sending billing information to a health insurance plan), for administrative purposes, and to evaluate the quality of care that you receive (such as comparing patient data to improve treatment methods).

B. We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, abuse or neglect reporting, auditing purposes, research studies, funeral arrangements and organ donation, workers compensation purposes, and emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may also contact you about appointment reminders or treatment alternatives or to raise funds. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

C. We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area, in each examination room, and on our Web site. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights

A. In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

B. You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. If this notice was sent to you electronically, you may obtain a paper copy of the notice.

C. You may request in writing that we not use or disclose your information for treatment, payment, or administrative purposes or to persons involved in your care except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request. Under no circumstance will you be retaliated against for filing a complaint.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

Effective date is May 19, 2003.

If you have any questions or complaints, please contact:

Christina Hutfless, General Counsel, Chief Legal, HR and Compliance Officer
200 High Park Ave.
Goshen, IN 46526
(574)-364-2898 E-mail: chutfless@goshenhealth.com