PHARMSCRIPT COVID-19 VACCINATION INFORMED CONSENT FORM

SECTION 1: PATIENT INFORMATION

This section must be completed for residents/facility staff receiving the vaccine.

Please check this box: ☐ **I consent to receive the following vaccination(s) (the "Vaccine"): SARS-CoV-2 Vaccine (2-dose series)**

First Name:	Last Name:	Date of Birth:	Gender: ☐ Male ☐ Female

Allergies: ☐ No Known Drug Allergies

Facility Name & Address:

Race/Ethnicity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino American ☐ Pacific Islander ☐ White ☐ Other, specify:

Mother's First Name: ☐ Unavailable	Mother's Maiden Name: ☐ Unavailable

Patient Guardian Type (Please select from the options below):

☐ Aunt	☐ Child	☐ Guardian	☐ Parent	☐ Sister	☐ Uncle	☐ Stepchild	☐ Father	☐ Sibling
☐ Brother	☐ Foster Child	☐ Grandparent	☐ Self	☐ Spouse	☐ Other	☐ Caregiver	☐ Mother	☐ Unavailable

SECTION 2: HEALTHCARE WORKER INFORMATION

Facility Staff receiving the vaccine must complete section 2 below.

Medical Conditions:

Mailing Address:

Personal Phone Number:	Personal Email Address:
Primary Care Provider (PCP):	PCP Phone Number:

Insurance Information (Please fill table below or check "No Insurance" if not insured)

☐ **No Insurance**	**Pharmacy/Medication**	**Medical**
Insurance Plan/Plan ID		
Member/Recipient ID Number		
Group Number		
RX BIN		N/A
RX PCN		N/A

Are you the cardholder? ☐ Yes ☐ No If no, please provide the Cardholder's name, date of birth and relationship below:

Cardholder Name:	Cardholder DoB:	Relationship to Cardholder:

SECTION 3: CONSENT

By signing I am indicating that I have reviewed all information below.

My signature below indicates that the nature of this consent was explained to me, I reviewed and voluntarily agree to all information below and that I had the opportunity to ask questions and my questions were answered to my satisfaction. If signing on behalf of the patient, please provide the following information::

☐ I am the legal and authorized representative of the patient and am authorized to sign this consent on the patient's behalf.

☐ The patient verbally agreed to all of the above and provided verbal consent but is unable to physically sign this consent form. Patient has verbally provided me with authorization to sign this consent on patient's behalf.

☐ The legal and authorized representative of the patient verbally agreed to all of the above on behalf of patient and provided verbal consent on behalf of the patient and verbal authorization for this consent to be signed.

Print Patient Name:	Date:
Print Guardian Name (if applicable):	Patient/ Guardian Signature:

Relationship to Patient (if applicable): ☐ Spouse ☐ Power of Attorney ☐ Legal Guardian ☐ Other (If "Other", refer to witness section)

Witness Signature (for "Other") (optional):	Print Name:

PLEASE READ THE FOLLOWING STATEMENTS.

I have received, read and understand the CDC's Vaccine Information Sheet(s) or the Emergency Use Authorization (EUA) Fact Sheet corresponding to the Vaccine. I hereby authorize PharmScript and the practitioners employed by or contracted with PharmScript (each, a "Provider") to administer the Vaccine I have requested above as a two-dose regimen series (the "Services"). I understand that I may withdraw this consent at any time by making a request in writing.

Provider(s) has provided me with information about the nature and purpose of the Services, expected benefits, potential known and unknown complications, likelihood of achieving goals, and relative risks that may arise from the Services, which depend upon my specific diagnoses and health status, along with the relevant risks and consequences of no treatment. I understand that administering Vaccines is not an exact science and there are no guarantees as to the results of the Services. I understand the benefits and risks of the Vaccine and I expressly consent, request, and authorize the Services. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless each Provider, PharmScript, and its officers, directors, managers, affiliates, employees, contractors, agents and representatives from any and all liability or claims, whether known or unknown, arising out of, in connection with, or in any way related to the Services.

I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registration ("State Registry") and my state's health information exchange ("State HIE"); and (b) the Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I further authorize the applicable Provider to: (a) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE to my healthcare professionals, Medicare, Medicaid, or other third-party payers as necessary to effectuate care or payment; (b) submit a claim to my insurer for the Services; and (c) request payment or authorized benefits be made on my behalf to the applicable Provider with respect to the Services.

I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the Provider: (a) the disclosure of my vaccination information by the Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The Provider will, if my state permits, provide me with an Opt-Out Form. I understand that I may need to consent, depending on my state's law, and to the extent so required, I hereby do consent by signing below to the Provider reporting my vaccination information to the State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent Form. Unless I provide the Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my vaccination information to or through the State HIE as required or permitted by law.