Full Name of Patient____

I consent and agree to receive a vaccination/s for COVID-19 from Harris County Public Health (HCPH).

The vaccination will be for the [please initial] __________ Pfizer vaccine: TWO doses.
You will be informed of when the second dose is available.

____
Patient/Guardian Initials

This consent is for both the first dose and the second dose of the two-dose vaccines.
I have been given written information about the vaccine and have had to opportunity to ask questions and to have my questions answered.

MEDICAL CONSENT AND AUTHORIZATION

____
Patient/Guardian Initials

In the event of an emergency or non-emergency situation requiring medical treatment of the patient during the vaccination process, I/we, the undersigned parent(s)/guardian(s) of the patient, give Harris County Public Health my/our consent and authorization for all medical treatment that is deemed necessary by qualified medical personnel for the proper care and treatment of the patient, including but not limited to administration of first-aid, use of an ambulance, and transfer to a hospital.

PRIVACY NOTICE

____
Patient/Guardian Initials

I have been given a copy of HCPH Privacy Notice, which includes the HIPAA Privacy Rule.
I have had the opportunity to have the HCPH Privacy Notice explained to me.
I understand that HCPH will use and disclose my Protected Health Information for treatment, billing and healthcare operations without my written authorization. I understand my rights as described in the Notice. I understand how to make a compliant if I feel my rights have been violated.

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that HCPH collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the agency to correct any information that is determined to be incorrect. For further information, contact Harris County Public Health – Health Information Services at 832-927-7647 or 832-927-7646.

REQUIRED FOR ALL PATIENTS

I attest that the information I have provided on this form is accurate and correct to the best of my knowledge. I hereby give my informed consent to the procedure/treatment/vaccination listed above. No warranty or guarantee has been made to me by the HCPH staff or contractors regarding the care or services that will be provided by HCPH. I certify that the services and care to be provided have been fully explained to me and my questions have been answered to my satisfaction.

____________________________	______________	____________________
Full Signature of Patient/Parent or Legal Guardian	Date	Relationship to Patient

Address of signor: ____

Updated: April 23, 2021