PERMISSION TO SHARE H1N1 VACCINE INFORMATION
(FOR ADULT IMMUNIZATION)

I, _____, give permission to the individual and/or entity that
(Print your name)
administered the 2009 H1N1 vaccine to me to share copies of the 2009 H1N1 vaccination record with my health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2009 H1N1 vaccination record with each other.

My health care provider:
Name: _____
Address: _____

- This health information is disclosed at my request and to ensure that I am appropriately vaccinated.
- This permission expires one year from the signature date.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain the vaccination.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

_____

(School/institution/individuals handling withdrawals MUST insert name and address above.)

However, if I withdraw permission at a later date, any vaccine record already shared will not be covered by the withdrawal.

_____ _____
Print name Signature

_____ _____
Address Date

Permission to share is compliant with HIPAA for billing and information sharing purposes.

October 5, 2009