

**PERMISSION TO SHARE H1N1 VACCINE INFORMATION
(FOR A CHILD IMMUNIZED WITH PARENT PRESENT)**

I, _____, give permission to the individual and/or entity that
(Print your name)
administered the 2009H1N1 vaccine to my child _____ to share
(Print child's full name)
copies of the 2009 H1N1 vaccination record with my child's school and 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 child's health care provider:

Name: _____
Address: _____

My child's school:

Name: _____
Address: _____
(at a minimum include Town)

- This health information is disclosed at my request and to ensure my child is appropriately vaccinated.
- This permission expires at the end of the 2009-2010 school year.
- 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 child's 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.

Printed name of Parent or Guardian

Signature of Parent or Guardian

Address

Date

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