Ascension

COVID-19 Vaccine Acknowledgement and Consent Form
Pfizer-BioNTech COVID-19 Vaccine FIRST DOSE

Recipient Information (Please Print Clearly)

Last Name:	First Name:	Date of Birth:
Home Address:		Phone:
City:	State:	Zip:

The following questions will help us determine whether you can receive the COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask a staff member for further explanation:

	Yes	No	N/A
Are you sick today?	❑	❑	
Do you have a history of severe allergies?	❑	❑	
Have you ever had a serious reaction after receiving a vaccination?	❑	❑	
Do you have a bleeding disorder or are you on a blood thinner?	❑	❑	
Are you immunocompromised or on a medication that affects your immune system?	❑	❑	
For women: Are you pregnant or planning to become pregnant?	❑	❑	❑
For women: Are you breastfeeding?	❑	❑	❑
Have you received any vaccinations in the past 2 weeks?	❑	❑	
Have you previously been diagnosed with COVID-19 and were treated with monoclonal antibodies within the last 90 days?	❑	❑	

I understand that the COVID-19 vaccine I will receive today requires two (2) doses from the same manufacturer to be fully effective. I understand I must return within 17-21 days of the first dose to receive a second dose of the vaccine. If more than 21 days have elapsed since the first dose, the second dose should be given at the earliest opportunity.

I consent to administration of the Pfizer-BioNTech COVID-19 vaccination and acknowledge and agree with the following statements:

- I am at least sixteen (16) years of age.
- I have received the Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers for the Pfizer-BioNTech COVID-19 Vaccine (the "Fact Sheet").
- I have read the Fact Sheet or had it read to me.
- The U.S. Food and Drug Administration (FDA) has authorized emergency use of the Pfizer-BioNTech COVID-19 vaccine, which is not an FDA-approved vaccine. At this time, there is no FDA approved vaccine to prevent COVID-19.
- I understand the known and potential risks and benefits to the Pfizer-BioNTech COVID-19 vaccine and the extent to which such benefits and risks are unknown.
- I acknowledge that I have the option to refuse vaccination and have been informed of any available alternatives to the Pfizer-BioNTech COVID-19 vaccine and the risks and benefits of available alternatives.

- Recipients who are Pregnant or Breastfeeding: Pregnant and breastfeeding persons were not included in the clinical trials for the Pfizer-BioNTech COVID-19 vaccine. I have discussed the potential risks of COVID-19 infection versus the risk of vaccination with my healthcare provider and have made the informed decision to receive the Pfizer-BioNTech COVID-19 vaccine.
- I understand that it is recommended that I remain at the vaccination clinic for fifteen (15) minutes following administration of the vaccine for observation (the "Monitoring Period") to ensure I do not experience an adverse reaction. Recipients that have a history of anaphylaxis should be monitored for thirty (30) minutes post vaccination.
- I acknowledge that I have received information on V-safe, a voluntary smartphone based tool operated by the Centers for Disease Control and Prevention (CDC). Through V-safe, vaccine recipients can report any side effects of the COVID-19 vaccine to the CDC. This information helps CDC monitor the safety of COVID-19 vaccines in near real time.
- I have had the opportunity to ask questions which have been answered to my satisfaction.

If you experience an adverse reaction to the COVID-19 vaccine, please contact your primary care provider or present to the nearest emergency department. If you are experiencing a medical emergency, call 911.

Signature of Recipient/Authorized Representative:	Date:
Print:	
If signed by Authorized Representative, please state relationship to Recipient:	

FOR CLINIC USE ONLY

Vaccine Administrator (Print Name):
Administration Date/Date Fact Sheet Provided:

Manufacturer	Lot Number	Expiration Date	Site of Administration

❒ Monitoring period completed and no adverse reaction noted.

❒ Recipient declined Monitoring Period. Waiver completed.

Signature of Observer: _____

❒ COVID-19 Acknowledgement and Consent Form and Monitoring Period Waiver (if applicable) uploaded to PureOHS *(for recipients who are Ascension associates, contractors, or medical staff members only).*

GENESYS | ST. MARY'S OF MICHIGAN | ST. JOSEPH HEALTH SYSTEM | ST. MARY'S OF MICHIGAN STANDISH HOSPITAL

One Genesys Parkway	800 S Washington	200 Hemlock, PO Box 659	805 W. Cedar St.
Grand Blanc, MI 48439-8066	Saginaw, MI 48601	Tawas City, MI 48764-065	Standish, MI 48658

HIPAA AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Ascension Genesys to release the following information from the medical records of:

Patient Name (Please Print)	**Date of Birth**	**MRN#**
Address		**Visit #**
Maiden/Other Names	Telephone #	

Including information as applicable:

Communicable disease and infection information, as defined by statute and Michigan Department of Public Health Rules (which include venereal disease "VD," tuberculosis "TB," hepatitis B, human immunodeficiency virus "HIV," acquired immunodeficiency syndrome "AIDS," and AIDS related complex "ARC") and (specify other, if known)

_____

Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2.
Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.

Release To: _____
Name and Address of person(s) or organization(s) to whom information is to be released

Release (please choose appropriately below)

- Only these specific documents _____
- Medical records for the dates of: _____

✓ I understand that if the person(s) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Genesys, St. Mary's of Michigan, St. Mary's of Michigan Standish and St. Joseph Health Systems, its employees, and my physicians from all liability arising from this disclosure of my health information to the extent indicated and authorized herein.

✓ I understand that I may inspect or request copies of any information disclosed by this authorization.

✓ I understand that I may revoke this authorization by notifying, in writing, the Health Information Management Department, knowing that previously disclosed information would not be subject to my revoked request. I understand that this authorization will expire sixty (60) days from the date of signing, or earlier for any of the specified dates, events, or conditions.

_____

✓ I understand that there may be a fee associated with this request. If there is a fee, I expect the organization to contact me before copies are made.

✓ By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the use or disclosure of my protected health information in accordance with the terms of this authorization.

_____ _____

Signature of patient Date Signature (Authorized Representative) Date

All areas must be complete for this form to be a valid request. If submitting by mail, please include a copy of your ID or DL

ID Verified _____ Date Released _____ Initial/sign: _____

Ascension GENESYS

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.

WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

We are legally required to protect the privacy of your health information. We call this information "protected health information" or "PHI" for short, and it includes information that can be used to identify you that we have created or received about your past, present, and future health or condition, the provision of healthcare to you, or the payment for this healthcare. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice. However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice near the main entrance to each health facility. You can also request a copy of this notice from the contact person listed in below at any time and can view a copy of the notice on our website at www.genesys.org.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We use and disclose health information for many different reasons. For some of these uses or disclosers, we need your prior specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each.

Uses and Disclosures Relating to Treatment, Payment or Health Care Operations

We may use or disclose your PHI for the following reasons:

- For treatment. We may use and disclose your PHI to physicians, nurses, medical students and other health care personnel who provided you with health care services or are involved with your care. For example, if you're being treated for a knee injury, we may disclose your PHI to the physical therapy department in order to coordinate your care.
- To obtain payment for treatment. We may use or disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.
- For health care operations. We may disclose your PHI in order to operate our hospitals, clinics, urgent care centers and other health care service locations. For example, we may use your PHI in order to evaluate the quality of health care services that you received or evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, and consultants who perform services on our behalf.

Other Uses and Disclosures That Do Not Require Your Authorization

- When disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement. For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect or domestic violence; when dealing with gunshot and other wounds, or when ordered in a judicial or administrative proceeding.
- For public health activities. For example, we report information about births, deaths and various diseases to government officials in charge of collecting information, and we provide coroners, medical examiners and funeral directors necessary information relating to an individual's death.
- For health oversight activities. For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
- For purposes of organ donation. We may notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.
- For research purposes. In certain circumstances, we may provide PHI in order to conduct research.
- To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
- For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.
- For workers' compensation purposes. We may provide PHI in order to comply with workers' compensation laws.
- Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders through the mail or by telephone or give you information about treatment alternatives, or other health care services or benefits we offer.
- Fundraising activities. We may use PHI to raise funds for our organization. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to be contacted as part of our fundraising efforts, please contact the person listed below at the end of this notice.

Uses and Disclosures to Which You Have an Opportunity to Object

- Patient directories. We may include your name, location in this facility, general condition in our patient directory and disclose it to visitors who ask for you by name, unless you object in whole or in part. We also may include your religious affiliation (if any) in the facility director and disclose facility directory information to clergy members, unless you object in whole or in part.
    - Disclosure to family, friends, or others. We may provide your PHI to a family member, friend or other person to the extent that person is involved with your care or payment for your health care, unless you object in full or in part.
    - Special Legal Restrictions. Frequently, Michigan law and/or Federal Regulations require explicit authorization for the disclosure of PHI of patients treated for mental health, substance abuse and HIV/AIDS conditions.

- All Other Uses and Disclosures Require Your Prior Written Authorization In any other situation not described in this section, we will ask your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization).

WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

- The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. However, if you pay in full out-of-pocket and you request that we not disclose any information to your health plan about this service, we must grant that request. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make related to your treatment.
- The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternative address (for example, to your work address rather than your home address) or by alternative means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.
- The Right to See and Get Copies of Your PHI. In most cases you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. If you request copies of your PHI, we will charge you a reasonable copying fee.
- The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include any of the uses or disclosures for treatment, payment and health care operation and some other purposes per the law. The list also will not include any of the uses or disclosures made before April 14, 2003. We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you $25 for each additional request.
- The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not required to be disclosed to you, or (iv) not part of your medical record. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.
- Notice by E-Mail. If you agree to receive this notice via e-mail, you still have the right to request a paper copy of this notice.
- Psychotherapy Notes. We must obtain your written authorization before we may use or disclose your psychotherapy notes, except for: use by the originator of the psychotherapy notes for treatment; use or disclosure by Covered Entity for its own mental health training programs; or use or disclosure by Covered Entity to defend itself in a legal action or other proceeding brought by the individual.
- Marketing. We must obtain your written authorization before we may use or disclose your PHI for marketing purposes, except for face-to-face communications made by us to you or a promotional gift of nominal value provided by us to you.
- Sale of PHI. We must obtain your written authorization before we sell your PHI.
- Breach of PHI. We are required to notify you in the event of a breach of your unsecured PHI.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with: Genesys Regional Medical Center HIPAA Privacy Office (see contact information listed below.)

You also may send a written complain to: Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint.

WHO WILL FOLLOW THIS NOTICE OF PRIVACY PRACTICES

This notice describes the practices of the employees, medical staff, volunteers, entities, departments, and units of Genesys Health System.

Also, these entities, sites and locations may share medical information with physicians and other healthcare professionals within Genesys Health System and as a Member of a Regional Health Information Organization ("RHIO") or other Health Information Exchange ("HIE"). If you want to "opt out" of the RHIO or HIE, please notify the Privacy Officer listed below.

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact HIPAA Privacy Officer at 810-606-7781. All complaints must be submitted in writing to:

Genesys Health System-HIPAA Privacy Officer
One Genesys Parkway
Grand Blanc, MI 48439-9816

EFFECTIVE DATE OF THIS NOTICE: April 14, 2003. REVISED: September 1, 2013

VETERANS ADMINISTRATION

I authorize the release of protected health information to the Veterans Administration for the sole purpose of eligibility and access to available benefits and services offered by the Veterans Administration, if applicable. ____ Initials

TEACHING INSTITUTION

I have been informed and understand that this facility is or is affiliated with a teaching institution and the medical and surgical procedures performed may require observation, cooperation, and services of multiple health care providers, including students and I authorize such personnel to undertake this observation and care. In addition, I understand that treatment and medical records may be reviewed by approved students and staff for teaching, study, and research purposes. Information identifying me will not be published without my prior consent. I understand that I will be asked at each visit if a student may participate in my care, and will be given the opportunity to refuse that participation.

ADVANCE DIRECTIVES

I have completed a Patient Advocate Designation or Durable Power of Attorney for Healthcare (DPAHC) _____ Yes _____ No

Patient Advocate Name: _____ Phone: _____-_____-_____

If "Yes" is checked above, I understand that I must provide the hospital with a copy of the Patient Advocate Designation or the DPAHC

Would you like more information about Patient Advocate Designations or Durable Powers of Attorney for Healthcare? ____ Yes _____ No

NON-DISCRIMINATION POLICY

I, the undersigned, acknowledge I have been offered a copy of the Non-Discrimination Policy from Ascension Genesys.

I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT (OR HAVE IT READ TO ME), ASK QUESTIONS, AND HAVE THESE QUESTIONS ANSWERED.

By signing this form, I acknowledge that I authorize/consent to medical care and have been offered and/or received the information designated above from Ascension Genesys.

Name of Patient (please print: _____ Date: _____

Signature of Patient/Legal Representative: _____ Date: _____ Time: _____

Relationship to Patient: _____ Date: _____ Time_____

Signature of Witness: _____ Date: _____ Time_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES AND PATIENT RIGHTS AND RESPONSIBLILITIES:

The Ascension Genesys Notice of Privacy Practices and Patient Rights and Responsibilities provides information about how protected health information about me (the patient) – may be used and disclosed. I understand that the terms of the Notice may change and a copy of the current Notice of Privacy Practice is available on the hospital's website or by contacting the Privacy Officer listed in the Notice.

The Patient Rights and Responsibilities handout provides information about patient rights, benefits, or privileges guaranteed by law. I understand that the law may change and a copy of the current Patient Rights and Responsibilities is available on the hospital's website or by contacting the Patient Relations Department.

I acknowledge that I have been provided the Ascension Genesys Notice of Privacy Practices and the Patient Rights and Responsibilities handout.

Name of Patient (print: _____

Signature of Patient _____ Date: _____ Time: _____

Consent of Legal Guardian or Patient Advocate if Patient is a Minor or Patient Advocate is currently Activated

Signature: _____ Date: _____ Time: _____

Relationship (check one): _____ Guardian _____ Patient Advocate

Reason patient declines to acknowledge being offered the Notice of Privacy Practice, after discussion with hospital representative:

Unable to sign: _____ Refused to sign: _____ Other: _____

Witness initials: _____ Date and Time: _____