COVID-19 Vaccine Consent & Release Authorization

(PLEASE PRINT)

Patient Last Name:	**First Name**:		**MI**:
Sex: ☐ M ☐ F	**DOB**: / /		**Age**:
Address:	**City**:	**State**:	**Zip**:
Cell Phone: ( )	**Alternate Phone:** ( )		

The following questions will help determine if there is any reason you should not receive a COVID immunization injection.

Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.

1.	Has the person to be vaccinated ever received a COVID-19 vaccine? Date_____...	☐ Yes	☐ No
2.	Does the person to be vaccinated have an allergy to a component of the vaccine?..... Allergies:_____	☐ Yes	☐ No
3.	Has the person to be vaccinated ever had a severe reaction to COVID-19 vaccine?.....	☐ Yes	☐ No
4.	Is the person to be vaccinated sick today?.....	☐ Yes	☐ No
5.	Is the person to be vaccinated younger than 18 years old?.....	☐ Yes	☐ No
6.	Is the person to be vaccinated pregnant, intending to be pregnant in the next 30 days or breastfeeding?.....	☐ Yes	☐ No

Request for Administration of COVID-19 Vaccine for the Above-Named Recipient:

I acknowledge that I have received the Vaccine Information Statement or Emergency Use Authorization Information Sheet. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I am aware that, to provide protection against the virus that causes COVID-19, two doses of this same vaccine may be required. I acknowledge that I may receive a reminder for a second dose by text (if cell phone number provided, standard messaging rates may apply), phone call, or mail. I hereby release The University of Tennessee Medical Center, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE: _____ **DATE/TIME:** _____

Patient Certification, Authorization to Release Information and Pay Request for Medicare and Medicaid / TennCare Benefits:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act and Medicaid/TennCare is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare or Medicaid/TennCare claim. I request the payment of authorized benefits be made on my behalf. This authorization and assignment shall be valid for one year.

Authorization to Release Information and Assignment of Insurance Benefits:

I hereby authorize the University of Tennessee Medical Center (UTMC) to release information requested by my insurance carrier. I assign UTMC the insurance benefits herein specified and otherwise payable to me, but not to exceed UTMC's regular charges for this period of hospitalization, and I authorize and direct my insurance carrier to make payment of said benefits directly to UTMC.

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE: _____ **DATE/TIME:** _____

** Authorized representative must be able to provide documentation in order to sign on behalf of patient.