

Insurance*: Please answer the following: This information is required for federal funding purposes for VFC vaccines.

***Note:** Vaccines will be provided to your child without cost to you if your child is eligible for the Vaccines for Children Program. If your child is covered by insurance, including Medicaid, the Department is required by law to seek reimbursement from the insurance plan for all allowable costs associated with the provision of the vaccine.

is not covered by private insurance, Medicaid, or FAMIS

is a foster child or is an Alaska Native

has Medicare - Medicaid # _____

has FAMIS - FAMIS # _____

has other insurance not listed above (specify plan) _____

Policy ID # _____

Policy holder's name _____

Attach a copy of the front & back of insurance card or provide the following information:

Insurance company address _____

Insurance company phone number _____

Office of Privacy and Security

Authorization for Disclosure of Protected Health Information

This consent gives the Virginia Department of Health (VDH) permission to disclose personal health information to the person(s) or organization(s) I have indicated.

- I understand the provision of treatment to my child cannot be conditioned on my signing of this authorization.
- Any health information redisclosed by me or my child will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included with my child's medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH to disclose my child's health information to his/her primary care physician and school.
- I understand that this record will be retained until my child reaches 21 years of age.
- I authorize VDH release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. The third party payer to pay any authorized benefits to VDH on my behalf.
- I understand this document will be given to and retained by the public health department and will not be maintained by the school.

Please check box if you wish to receive a copy of the Virginia Department of Health Privacy Rights.

Please send a copy of my child's immunization record to her/his doctor at the following address.

Doctor's Name _____

Mailing Address _____

City _____

State _____

ZIP _____

