

PLEASE BRING THIS TO DRIVE THRU CLINIC

FRANKLIN COUNTY HEALTH DEPARTMENT
1418 S MAIN, SUITE 1 OTTAWA, KANSAS 66067
785-229-3530

NAME: _____ DATE OF BIRTH: _____ AGE: _____

PHONE: _____ SEX: Male ___ Female ___ Marital status M S W

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

Name as it appears on Medicare/Medicaid Card _____

Medicare/Medicaid Number _____

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child injectable influenza vaccination today. If you answer "yes" to any question, it does not mean your (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain.

- | | | | |
|--|-----|----|------------|
| 1. Is the person to be vaccinated sick today? | Yes | No | Don't know |
| 2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? | Yes | No | Don't know |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | Yes | No | Don't know |

INFLUENZA (FLU) VACCINE ADMINISTRATION RECORD

The doctor or clinic may keep this record in you medical file or your child's medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that manufactured the vaccine, the vaccine's special lot number, the signature and title of the person who gave the vaccine and the site where the vaccine was given.

I have been given a copy and have read, or have had explained to me, the information in the "Vaccine Information Statement" (VIS) regarding the influenza vaccine. YES _____ NO _____

Signature of person to receive the vaccine or person authorized to make the request (parent or guardian): I believe I understand the benefits and risks of the Influenza (FLU) vaccine and ask that the vaccine be given to me or to the person named for whom I am authorized to make this request.

Signature of Client _____ Date _____

FOR OFFICE USE ONLY

Clinic Site 030 Date of Injection: September 11, 2010 Injection site _____

Manufacturer: Sanofi Lot # _____ ExpDate: 6/30/2011

Signature of Nurse _____

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**ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A
COPY OF THE FRANKLIN COUNTY HEALTH
DEPARTMENT'S NOTICE OF PRIVACY PRACTICES
WITH THE EFFECTIVE DATE OF APRIL 14TH, 2003**

Signature of Patient/Patient Representative

Date

Printed Name of Patient

Relationship to Patient

Name of Minor Child

Franklin County Health Department Notice of Privacy Practice

This Notice of Privacy Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information. "Protected health Information" is about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your local Health Department, office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the Health Department's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provided care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your Health Department practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when our medical staff is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: As Required by Law; Public Health issues as required by law; Communicable Disease; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donors; Research; Criminal Activity; Military Activity and National Security; Workers' compensation; Inmates; Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Environment to investigate or determine your compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

Your may revoke this authorization, at any time, in writing, except to the extent that the health Department has taken any action in reliance on the use or disclosure indicated in the authorization.

2. **Your Rights:**

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The Health Department is not required to agree to a restriction that you may request. If the health Department believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively; (i.e. electronically).

You have a right to have the Health Department amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.