LIVINGSTON COUNTY
DEPARTMENT OF HEALTH
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"Commitment to Leading The Community for a Healthier and Safer Tomorrow"

Consent Form COVID-19 Vaccine

I request that the vaccine(s) be given to me or the person named on form, for which I am authorized to make this request. I understand the benefits and risks of the vaccination(s). I authorize the agency to submit charges and necessary health information to my insurance for payment consideration. I understand that I will not be held responsible for any uncovered amount.

Signature: _____ ***Date:*** _____

Please Print:

Insurance Information

Name of Patient	
Name of Insurance or None	
Insurance ID	
Subscriber Name	
Subscriber Phone Number	
Subscriber DOB	
Subscriber relation to patient	