INFLUENZA VACCINE RECORD
2020/2021

The doctor or clinic may record this information in electronic format. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's lot number, the signature and the title of the person who gave the vaccine, and the address where the vaccine was given.

"I have read or have had explained to me the information about influenza and the influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and ask that the vaccine be given to me or to the person names below for whom I am authorized to make this request."

ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)
As Client/Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. **I am personally responsible for charges not covered by this assignment.**

Medicare Patient Certification, Authorization to Release and Payment Request (Only applies to Medicare Clients)
As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize Dixie/Gilchrist/Levy County Health Departments to release Protected Health Information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the Dixie/Gilchrist/Levy County Health Departments and authorize them to submit a claim to Medicare for payment.

_____ _____ _____/_____
INSURANCE NAME **INSURANCE NUMBER** **SEX** **RACE**

_____ _____ _____
NAME: LAST **FIRST** **MI** **DOB**

_____ _____
ADDRESS **CITY** **ST** **ZIP** **PHONE**

X_____ **DATE**_____
Signature of person to receive vaccine or person authorized to make the request (parent/guardian).
By my signature above I verify the above information and receipt of the notice of privacy rights.

FOR CLINIC/OFFICE USE

Site:_____

Date Vaccine Administered:_____ **Site of Injection:**_____

Vaccine Manufacturer:_____ **Lot Number:**_____ **Exp. Date:**_____

Signature of Vaccine Administrator:_____ **Title:**_____