AUTHRELSE

MUSC, Hollings Cancer Center Mobile HPV Vaccination Van
Authorization to Disclose Protected Health Information

Form Origination Date: 2/2022
Version: 1 Version Date: (2/2022)

Patient Name ______________________________

MRN______________________________

PATIENT IDENTIFICATION LABEL

Patient Name: ______________________________
(legal name)

All healthcare information is private. By signing this form, you are giving the MUSC, Hollings Cancer Center Mobile HPV Vaccination Van (the “Vaccination Van”), the school nurse, and the above-named patient’s health care provider consent to speak with and share medical information about the vaccines given with providers providing care on the Vaccination Van. This information will be treated as confidential protected health information.

The purpose of this disclosure is: participation in mobile vaccination services.

Examples of protected health information that may be shared include but are not limited to: medical history, demographic information, vaccination records.

I understand that permitting the release of protected health information is voluntary. I can refuse to sign this form. I do not need to sign this form to receive treatment. I understand I may review and/or copy the information disclosed, as provided in 45 CFR 164.524.

I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person/organization receiving the information. Upon request, I understand I will be given a copy of this authorization. Parental consent for release of health information is not required for students who are 16 years or older.

____ ______________

Signature of Patient or Legal Guardian/Representative Date
(or Student if 16 years or older or otherwise permitted by law)

____________________________ ______________________ ___________

Witness Printed Name Witness Signature Date

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Printed Name Patient or Legal Guardian/Representative Date
(or Student if 16 years or older or otherwise permitted by law)

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Relationship to Patient