Patient Information

Name:		
Mailing Address:		
City:	State:	Zip Code:
Date of Birth:	Email:	
Cell Phone:	Home Phone:	Is the Patient an American Indian or Alaskan Native? ____ YES ____ NO
Name of Parent or Guardian if applicable (Print):		

Responsible Party or Parent of Minor Child

Parent's Name:		
Date of Birth:		
Cell phone:	Home Phone:	
Parent's Name:		
Date of Birth:		
Cell phone:	Home Phone:	

Insurance Information

Primary Insurance Name:	
Member ID #:	
Group #:	
Policy Holders Name:	
Date of Birth:	Relationship:
Secondary Insurance Name:	
Member ID #:	
Group #:	
Policy Holders Name:	
Date of Birth:	Relationship:

I acknowledge that I have been offered a copy of the Chaffee County Public Health Notice of Privacy Practices.

Signature _____ Date _____

Consent for Public Health Services/ Assignment of Benefits

I have read, or I have had explained to me, information about the vaccines and/or services to be administered. I have had the opportunity to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of these vaccines and/or services and ask that they be administered to me or the person named previously, for whom I am authorized to make this request. I also acknowledge that I have been offered copies of the appropriate Vaccine Information Statements (VIS) if applicable. _____ (Initials)

I am aware that I am responsible for all fees for immunizations and services provided to me or for those who are my dependents. I also understand that payment is due at the time of the service unless arrangements for insurance billing or private billing are made and authorized by Chaffee County Public Health personnel. _____ (Initials)

I hereby authorize and direct my insurances carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to Chaffee County Public Health for the medical services rendered to myself or my dependents. Patient understands and agrees that the County may share patient health and insurance information with third party providers for the purposes of assisting providers to provide services to patient and to seek reimbursement from patient's insurance.. I understand that I am responsible for any amount not covered by insurance. _____ (Initials)

I am aware that each of these consents will remain in effect for two (2) full years from the date of signature unless canceled in writing.

Signature of Patient, Parent, or Guardian _____ Date _____

Signature-Chaffee County Public Health Staff _____

Authorization for Release for Information-from Chaffee County

The undersigned herby grants permission to Chaffee County Public Health to release the following medical records of (Patient): _____
to: (name and address/fax number of recipient):
_____
_____
_____.

The information to be released is: ____ the entire medical record; or _____ specific records as follows:
_____
_____.

I understand that this release will remain in full force and effect for two (2) years from the date of my signature below unless it is revoked in writing by me. I may revoke this release by giving written notice of revocation to Chaffee County Public Health at 448 E. 1st. Street, Suite 137, Salida, CO 81201. I understand that a revocation is not effective to the extent that any person has already acted on the basis of this release.

I understand that this release is voluntary and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

If signed by someone other than Patient, Signer represesnts that he/she has authority to sign for Patient.

_____
Signature of Patient or Person Acting on Patient's Behalf

_____
Date

_____
Printed Name of Person Signing

_____
Description of Signer's Authority if not Patient (e.g. parent/guardian)

CHAFFEE COUNTY
Public Health

Chaffee County Public Health

448 E. 1st Street • Suite 137 • Salida, CO 81201 • Phone: 719-539-4510 • Fax: 719-539-7197