LINCOLN COUNTY PUBLIC HEALTH
418 Mineral Ave | Libby, MT 59923
(406) 283-2447
www.lincolnmthealth.com

CONSENT FOR VACCINE AND BILLING FORM

Patient Last Name: _____ M. I.: _____ First Name: _____

Date of Birth: _____ Age: _____

Mailing Address: _____City: _____ State: __MT__ Zip Code: _____

Phone: _____ County: _____Lincoln_____

Email: _____ Gender: M F

Vaccine(s) to administer: _____

Insurance Information (skip if none)**:**

Primary Insurance Plan: _____

Policy #: _____

Group #: _____

Secondary Insurance Plan: _____

Policy #: _____

Group #: _____

Are you the insurance plan policy holder? YES NO

If no, please fill out the following:

Policy Holders Name: _____

First M.I. Last

Date of Birth: _____

Phone: _____

Administrative Use ONLY:

Qualify for:

VFC - YES NO

VFA - YES NO

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imMTrax Consent

By signing below, I authorize my health care provider and public health agency to collect and enter my immunization records into the Department of Public Health and Human Services' Immunization Information System (II). The IIS is a confidential computer system that contains immunization records and is the primary medical record system that LCPH uses. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my medical care and treatment. In addition, information may be released to schools or daycares in order to comply with immunization requirements. I understand that I can revoke this authorization and have my record removed at any time.

☐ Check here if you **DO NOT** wish to have your information on imMTrax.

Vaccine Consent

By signing below, I agree that I have read or have had explained to me the information about the vaccine(s) being administered. I have received or been offered the Vaccine Information Statement (VIS) for each of the vaccines indicated. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risk s of the vaccine(s) and ask the vaccine(s) be given to me or to the person named for whom I am authorize to make this request. I understand my financial obligation to pay the co-payments and deductible payments required by my insurance coverage and all charges for services not covered by my insurance plan.

Privacy Policy

By signing below, I agree that I have been offered or have read the LCPH Patient Privacy Policy and I understand my rights regarding my health information created or saved by LCPH. I also understand that in certain situations my health information may be shared without my consent as stated on the LCPH Patient Privacy Policy. I hereby agree and consent to the Patient Privacy Policy.

X_____ Date: _____

Parent/Guardian Signature