Hartford HealthCare

6816

Patient label

HARTFORD HEALTHCARE COVID-19 VACCINATION CLINICAL CONSENT AND AUTHORIZATION FOR DISCLOSURE

Section 1: Consent

I consent to the receipt and administration of the SARS-CoV-2/COVID-19 vaccine (the "Vaccine"). I understand the benefits and risks of vaccination, and I believe the benefits involved outweigh the risks. I voluntarily assume full responsibility for any reactions that may result from either my receipt of the Vaccine or the receipt of the Vaccine by any persons for whom am a legal guardian. I am hereby requesting that the Vaccine be given to me (or to a person to whom this consent applies and for whom I am the legal guardian or personal representative). I, on behalf of myself (and, if applicable, as legal guardian or personal representative for another), and each of my/our respective heirs, executors, personal representatives, agents, or assigns, hereby release Hartford HealthCare Corporation and each of its Member Organizations (including Hartford Hospital, The Hospital of Central Connecticut, Midstate Medical Center, Natchaug Hospital, Rushford, The William Backus Hospital, Windham Hospital and Hartford HealthCare Medical Group), and all of their affiliates, subsidiaries, divisions, pharmacies, directors, contractors, agents, and employees (collectively, the "Released Parties") from any and all claims or potential claims, injury, loss, damage, or death arising out of, in connection with, or in any way related to my receipt of the Vaccine (or, if applicable, the receipt of the Vaccine by a person for whom I am legal guardian or personal representative), including, but not limited to, claims or potential claims regarding short-term or long-term adverse effects, negligence or recklessness in administration, any ineffectiveness of the Vaccine, or for any other reason related to the Vaccine. I intend for this to operate as a General Release related to the Vaccine under the law and, therefore, for the avoidance of doubt, none of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by me or any other person for whom I am legal guardian or personal representative in connection with or as a result of its administration or provision of the Vaccine, or for any other reason related to or regarding the Vaccine.

I also acknowledge and agree that, if the Vaccine requires more than one dosage or administration, this Consent applies to all doses or administrations on this date or in the future, administered by or on behalf of any one or more Released Parties. I agree and acknowledge that I am fully and solely responsible for ensuring that I receive all necessary, required, or suggested doses; that none of the Released Parties is responsible for ensuring that I receive all necessary, required, or suggested doses; and that I hereby release the Released Parties from any claims or potential claims arising out of my failure to receive all required, necessary, or suggested doses of the Vaccine.

I further understand that I should remain in the Vaccine administration area for at least 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call a hospital or a doctor, or call 911.

I acknowledge that I have been provided with a Vaccine Information Sheet or patient fact sheet corresponding to the Vaccine – a copy is also available at:
https://www.fda.gov/media/144414/download (for the Pfizer-BioNTech vaccine) or
https://www.fda.gov/media/144638/download (for the Moderna vaccine) or
https://www.fda.gov/media/146304/download (for the Janssen vaccine) – and that I have been and will be afforded the opportunity to ask any questions on my behalf or on behalf of the person receiving the Vaccine for whom I am legal guardian or personal representative before it is administered.

Section 2: Authorization for Disclosure

I hereby authorize Hartford HealthCare Corporation and each of its Member Organizations, with respect to information, including protected health information and any information regarding adverse drug reactions or side effects, related to its administration of a SARS-CoV-2/COVID-19 vaccine to me ("COVID-19 Vaccine Information"), to:

1. Maintain and retain COVID-19 Vaccine Information in HHC's electronic health records systems (for example, EPIC or MyChartPlus) that are used in the administration, tracking, or reporting of COVID-19 Vaccine Information;

2. Use, disclose, or share COVID-19 Vaccine Information in order to treat me, bill for services, or conduct other health care operations, including by disclosing information to those within HHC responsible for COVID-19 vaccine administration, protocols, and procedures;

3. Use, disclose, or share COVID-19 Vaccine Information with my physician or other healthcare provider, my insurance plan or government payor, or other health systems or hospitals; and/or

4. Maintain, use, disclose, or share COVID-19 Vaccine Information as permitted or required by law, including to state and/or federal agencies or authorities, to state and/or federal registries, or to third parties as required or requested by state or federal agencies or authorities.

I hereby confirm and acknowledge that I have been given an opportunity to review, and have in fact reviewed, HHC's Joint Notice of Privacy Practices, which are available at the following link: https://hartfordhealthcare.org/File%20Library/NOPP/HHC-Joint-Privacy-Notice.pdf. I understand that HHC will use and disclose COVID-19 Vaccine Information as set forth in that Notice.

If I am an HHC employee, I also understand that, I am acknowledging and agreeing that my COVID-19 Vaccine Information will be retained in EPIC as part of my colleague medical record, which may be shared within HHC on an as-needed basis with, for example, the Infection Prevention team, Colleague Health, and my manager.

I understand and acknowledge that if I do not sign below or provide verbal acknowledgment of my assent to this Clinical Consent and Authorization for Disclosure, HHC will not administer a COVID-19 Vaccine to me.

_____	_____	_____
Patient or Legal Authorized Representative Signature	Date	Time

_____	_____	_____
Signature of Witness	Date	Time