NEW YORK STATE | Office of Mental Health | Office of Addiction Services and Supports

COVID-19 Immunization Consent Form for OASAS Service Recipients

Name and Address of Person(s) or entity(ies) to Whom this Information Will Be Disclosed: The Citywide Immunization Registry (CIR; for New York City) – OR – The New York State Immunization Information System (NYSIIS; for New York State outside of NYC).

Purpose for Release of Information: Immunization reporting required by Executive Order.

I understand have the right to revoke this authorization at any time except to the extent that action has already been taken based on this authorization.

Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent, including an inability to receive the COVID-19 vaccination at this time.

Alcohol/drug treatment related information or confidential HIV related information released through this form must be accompanied by the required statements regarding prohibition of redisclosure.

Signature:_____Date:_____

Recipient Name (please print)			DOB
Gender **Key:** M – Male F – Female O – Other	Ethnicity **Key:** HIS – Hispanic NHL – Non-Hispanic UNK – Unknown	Race **Key:** AIA – American Indian or Alaska Native ASN – Asian BAA – Black or African American NHP – Native Hawaiian or Pacific Islander WHT – White OTH – Other or Multiracial	
Address	City	State	ZIP
Parent/Guardian/ Surrogate (if applicable, please print)		Phone	Preferred Language
Clinic/Office Site Where Vaccine is Administered			

Insurance Information. NOTE: your health insurance information does not affect your ability to receive a vaccine. Everyone, even if you have no insurance, can get vaccinated at no cost to themselves. We need insurance information because New York State may be able to receive payment from insurance companies for providing vaccines.

Primary Insurance Name	Primary Insurance ID#	Subscriber Name/DOB	Subscriber Relation to Patient
Primary Insurance Address	Primary Insurance Group #	Primary Insurance Phone #	
Secondary Insurance Name	Secondary Insurance ID#	Subscriber Name/DOB	Subscriber Relation to Patient
Secondary Insurance Address	Secondary Insurance Group #	Secondary Insurance Phone #	
☐ I do not have health insurance at this time.			

Screening Questionnaire			
In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	◯ Yes	◯ No	◯ Unknown
Have you been treated with antibody therapy for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?*	◯ Yes	◯ No	◯ Unknown
Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot?	◯ Yes	◯ No	◯ Unknown
Have you had any vaccines in the past 14 days (2 weeks) including flu shot+? *If yes, how long ago was your most recent vaccine?*	◯ Yes	◯ No	◯ Unknown
Are you pregnant or considering becoming pregnant?	◯ Yes	◯ No	◯ Unknown
Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	◯ Yes	◯ No	◯ Unknown
Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	◯ Yes	◯ No	◯ Unknown

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

Recipient/Surrogate/Guardian (Signature) Date / Time Print Name Relationship to patient, if other than recipient

Telephonic Interpreter's ID # Date / Time

Below to be completed by Vaccinator

Which vaccine is the patient receiving today?				
Vaccine Name	Administration		EUA Fact Sheet Date	Manufacturer & Lot Number
Pfizer/ BioNTech	□ First Dose	□ Second Dose		
Moderna	□ First Dose	□ Second Dose		
Johnson & Johnson	□ First Dose	XXXXXXXXX		

Administration Site	□ Left Deltoid □ Right Deltoid □ Left Thigh □ Right Thigh
Dosage	□ 0.5 ml □ 0.3ml

☐ I have reviewed side effects with patient (and parent, guardian, or surrogate, as applicable).
☐ I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

Vaccinator Signature: _____