AUTHORIZATION – FOR RELEASE OF HEALTH INFORMATION TO THIRD PARTY
FLU VACCINATION FORM

By choosing to use this vaccination clinic to obtain your flu shot, your signature below allows for your flu shot information to be shared with Johns Hopkins Vaccine Management System to ensure you are in compliance with the Designated Entity's influenza vaccine policy.

Section 1: Patient information

Patient Name: _____
Date of Birth: _____
Street Address: _____
City, State, Zip: _____
Telephone Number: ( ) _____ E-mail Address: _____

Section 2: Entity authorized to receive information from Walgreens. The Johns Hopkins University and or Johns Hopkins Health System Corporation and their affiliates ("Designated Entity").

Section 3: Information you are agreeing to release: Information related to my influenza vaccination including my vaccination appointment information.

Section 4: Purpose: I am currently associated with the Designated Entity and request that the Designated Entity receive information related to influenza vaccination.

Section 5: Expiration Date: This authorization expires one year from the date of my signature.

Section 6: Information regarding this Authorization

- You have the right to revoke this Authorization, in writing to Walgreens Privacy Office, at any time. The revocation is only effective after it is received and logged by Walgreens. Any use or disclosure made prior to a revocation is not included as part of the revocation.
- Refer to our Notice of Privacy Practices for permitted uses and disclosures of protected health information ("PHI"). You may obtain a copy of this Notice from the Privacy Office or on www.walgreens.com. Please keep a copy of this authorization for your records.
- **Once PHI is disclosed to others, it may be redisclosed by them to persons or entities that are not subject to the privacy regulations, which means that the PHI may no longer be protected by regulations**.
- Privacy regulations prohibit the conditioning of treatment, payment, enrollment, or eligibility for benefits on signing this Authorization.
- This Authorization must be signed and dated by the patient or signed and dated by the patient's personal representative to include a description of that person's ability to act on behalf of the patient.

Section 7: Signature

I, _____, by signing below, authorize Walgreens to use or disclose of my protected health information as described above.

_____
Signature Date

Section 8: If this Authorization is signed by the patient's personal representative, please explain your authority to act

_____

If you have any questions regarding this form, you can contact Walgreens Privacy Office,
200 Wilmot Road, MS 9000, Deerfield, Illinois 60015; Phone: (847) 236-6518;
Fax: (847) 236-0862.