Authorization for Immunization Proxy of Minor

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An immunization proxy is a person who is authorized by the legal parent or guardian to bring child/children in for scheduled immunizations as recommended and/or required by the CDC. The designated proxy must be at least the legal age of 18 and must present legal identification at the time of vaccination.

I, _____, (legal parent or guardian) hereby authorize

the designated proxy, _____to bring the designated child/children listed below:

First and Last Name	Date of Birth

to the Adams County Health Department to receive immunizations as outlined in accordance with the schedule of immunizations required and/or recommended by the CDC and supported by the standing orders signed by medical director of the Adams County Health Department, Dr. James Daniels

This proxy designation is valid from the date of signature_____ until the date it is rescinded by the Parent/Guardian or until the child/children reach the age of 18 years.

I understand that I have the right to revoke this authorization by giving written notice to the health department. If I refuse to sign this authorization, the above–described authorization will not be allowed except as provided by law.

I understand that this authorization for designated proxy is voluntary, and the health department may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization unless I am to receive health care solely for the purpose of creating protected health information to be disclosed to a third party or as otherwise authorized by law.
I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that this authorization is valid until the date of expiration stated above, or until I revoke it in writing by delivering a written revocation the health department.

I understand the nature and consequences of receiving services and they will be explained to me. I understand the health department is already authorized to use the information gained during treatment to bill me or any other potential source of reimbursement, such as government programs in which I am enrolled or qualified services. I also hereby acknowledge that I may receive a copy of the "Joint Notice of Privacy Practice" upon request by the health department.

I have a right to inspect and copy the information contained in my designated record set. I am entitled to a copy of this authorization if the health department is seeking this authorization.

Signature: _____ Date: _____

FOR STAFF USE ONLY

Identity of person making request for Proxy of Minor was verified by: ☐ Driver's License ☐ Birth Certificate.

Check if any of the following apply:

☐ Parent or Guardian of minor ☐ Guardian with power to make health care decisions.

☐ Power of Attorney for Health Care ☐ Mental Health Treatment Preference Declaration Agent ☐ Health Care Surrogate

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