PARENT/GUARDIAN CONSENT TO UNACCOMPANIED MINOR PATIENT'S RECEIPT OF COVID-19 VACCINE

Instructions:

1. Essentia Health patients who are under the age of 18 must have written consent from the parent or guardian ("caregiver") to receive the COVID-19 vaccine if a parent/guardian is not physically present to provide consent. Failure to present a signed, written consent form will result in cancellation of the vaccination appointment.
2. Caregivers must review and acknowledge receipt of the Fact Sheet for Recipients and Caregivers About Community and Pfizer BioNTech COVID-19 Vaccine to Prevent Coronavirus Disease 2019, which are available here:
   - For 12 years of age and older: https://www.fda.gov/media/153716/download
   - For 5 through 11 years of age: https://www.fda.gov/media/153717/download
3. Caregivers must also sign the Essentia Health "General Consent and Authorization."
4. Unaccompanied minors must bring both signed forms to the appointment.

CONSENT TO MINOR'S RECEIPT OF COVID-19 VACCINE AND ACKNOWLEDGMENT OF EUA FACT SHEET

Printed Name of Unaccompanied Minor Patient: _____

Unaccompanied Minor Patient's Date of Birth: _____

Printed Name of Parent/Guardian ("Caregiver"): _____

By your signature below, you are agreeing to the following statements:

- Recipient/caregiver is voluntarily accepting the COVID-19 vaccine after opportunity for discussion and questions of risks and benefits. The recipient/caregiver has had the opportunity to review the "Fact Sheet for Recipients and Caregivers" and understands that the vaccine is an unapproved vaccine that is authorized for use under the Emergency Use Authorization for 5 to 15 year olds (vaccine has received full Food and Drug Administration approval for 16 and 17 year olds). The recipient/caregiver acknowledges receipt of the information in the Fact Sheet in advance of the vaccine administration. This acknowledgment will be recognized as the recipient/caregiver's authorization or agreement for the above-named minor to undergo administration of both doses (if applicable) of the COVID-19 vaccine.

_____ _____

Parent/Guardian ("Caregiver") Signature Date

FOR ESSENTIA HEALTH USE ONLY - IF WRITTEN CONSENT COULD NOT BE OBTAINED AND VERBAL CONSENT MUST BE OBTAINED. If verbal consent is obtained – the parent/guardian must be directed to the EUA Fact Sheet for Recipients and Caregivers (online or in email) in advance of obtaining consent. Please read aloud the "Recipient/caregiver is voluntarily accepting the vaccine…" statement above.

I, _____, witnessed the verbal consent of the above-named parent/guardian for the vaccination of the above-named minor.

Essentia Health Witness Name: _____

Essentia Health Witness Title: _____

Essentia Health Witness Signature: _____

Date Verbal Consent Witnessed: _____

Time Verbal Consent Witnessed: _____

Phone number of parent/guardian that was called: _____

_____

Patient Name & Medical Record Number OR
Patient Label

Essentia Health

GENERAL CONSENT AND AUTHORIZATION

In order for Essentia Health to treat you, we ask you to sign below indicating your consent to treatment:

A. I give my consent to Essentia Health doctors and healthcare workers to perform exams, treatments, x-rays, lab tests and operations, and to give me medicine that they believe is necessary or helpful to my health.

B. I understand that while I am receiving care, a healthcare worker may accidentally be exposed to my blood or other body fluid. If this rare event occurs, I consent to have my blood tested for blood-borne pathogens, such as Hepatitis B and C, and HIV. I understand that the test results will become part of my medical record and will be released to the exposed healthcare worker and a positive result must be reported to the state by law.

C. I authorize payment from Medicare, Medicaid, insurance and any other funds be paid directly to Essentia Health for my care and treatment. I understand that it is my responsibility to comply with the requirements of my insurance policies.

D. I agree to pay any charges not covered by insurance, government programs (including Medical Assistance), or other funds. I further agree to pay reasonable attorney fees and all costs of collection in the event my account is turned over to an attorney or collection agency. I understand that it is my responsibility, not Essentia Health's, to negotiate for payment of a claim that is disputed by the payer.

E. A copy of the Patient Bill of Rights, information on Healthcare Directives, and information about how to file a complaint has been given to me.

F. I request that payment of authorized Medicare benefits be made on my behalf to Essentia Health for any services furnished me by an Essentia Health provider and/or in an Essentia Health facility. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefits for related services.

G. I request that payment of authorized MediGap (supplemental insurance) benefits be made on my behalf to Essentia Health for any services furnished to me by an Essentia Health provider and/or in an Essentia Health facility. I authorize any holder of medical or other information about me to release to my MediGap carrier any information needed to determine these benefits or benefits for related services.

H. I authorize Essentia Health to utilize my 60 lifetime reserve days as necessary after expiration of regular Medicare Benefits. I understand if reserve benefits are used, there will be co-insurance due, and once used they are permanently reduced by the number of days used.

I. I consent for medical photographs to be made of me (or the person for whom I am legal guardian). I understand that the information may be used in my medical record, and/or for purposes of medical teaching. Refusal to consent to photographs will in no way affect the medical care I will receive.

J. I acknowledge and understand I am responsible for my personal valuables (including money, jewelry, dentures, hearing aides, eyeglasses, etc.) while a patient at Essentia Health. While a patient, I have been encouraged to send all personal items of value home with relatives or friends. I also acknowledge I have been informed of the availability of safekeeping for my personal valuables. I release Essentia Health from any liability for loss by theft or negligence of mine or any hospital employee of my personal valuables.

Essentia Health respects your right to privacy. Under the following conditions your health information will only be released with your consent:

K. I authorize Essentia Health to release my medical records to, and as needed, to discuss my care with my doctors, other healthcare providers, and anyone else Essentia Health either believes to be involved in, or who may participate in my care, treatment, case management and/or discharge planning. This includes source documents (such as x-rays). I authorize Essentia Health to electronically release my protected health information to other healthcare providers involved in my care and treatment and who share electronic medical record systems with Essentia Health. This includes information related to the diagnosis and treatment of mental illness, alcohol or drug use, sexually transmitted diseases (STDs), HIV test results, developmental disabilities and genetic testing results.

L. To improve the coordination of my care, I authorize Essentia Health to electronically release my protected health information to other healthcare providers involved in my care and treatment and who participate in local, state and/or national Health Information Exchanges. This may include information related to the diagnosis and treatment of mental illness, alcohol or drug use, sexually transmitted diseases (STDs), HIV test results, developmental disabilities and genetic testing results.

M. I authorize Essentia Health to release my protected health information to insurance companies, government programs, and other parties who are responsible for, or who facilitate, payment of my bill, fraud investigation, care management, or quality improvement. This includes behavioral health and chemical dependency information. Essentia Health may also release my protected health information to suppliers of medical equipment, special transportation, or other health services so they can request payment from my insurance or other payer. I also authorize Essentia Health to release my protected health information to organ procurement organizations to facilitate donations, and to e-Prescribing networks to facilitate prescription management.

N. I authorize Essentia Health to release information from my medical records: as needed by the Federal Food and Drug Administration (FDA) or manufacturers of drugs or medical devices to contact me about defects or recalls; or to emergency service providers involved in my care before and during transport to Essentia Health, for quality improvement.

O. I authorize Essentia Health to release information from my medical records and source data as needed to accrediting organizations and to legally authorized agencies to oversee healthcare activities and to physician specialty boards for board certification/re-certification of physicians.

_____

Patient Name & Medical Record Number
OR
Patient Label

GENERAL CONSENT AND AUTHORIZATION

P. I authorize Essentia Health to release information from my medical and billing records for scientific and health services research to improve patient care and delivery. I may object at any time to release of my protected health information for scientific research.

Q. If I have agreed to participate in Guarantor Billing, I authorize my bill to be combined into one statement that, as applicable, covers my current spouse and minor children with the same mailing address. This statement will be sent to the guarantor listed on my account. The combined billing statement will include patient name, the date of service, the location of service, a brief summary of the services received (including type/name of diagnostic tests) and the amount due. I authorize Essentia Health to discuss billing or payment-related issues with the listed guarantor who provides my name, address, date of birth, and my Essentia Health account number(s) for the dates of service to which this authorization applies, as well as his or her own name and address.

R. I authorize Essentia Health to disclose my presence and religious preference to Essentia Health Chaplains and to clergy of my denomination, and to disclose my presence to foundations that support Essentia Health and its mission. I understand that Essentia Health will ask specific permission before disclosing my presence for behavioral health or chemical dependency services.

S. I agree to the presence of students, observers from other healthcare facilities, healthcare consultants and approved representatives of medical service providers during tests, exams, medical treatments and other services at Essentia Health. I understand that Essentia Health will also seek my oral permission to have non-Essentia Health persons present during any services.

T. I authorize my health insurance plan to release to Essentia Health my protected health information about services I have received from Essentia Health and other care providers unrelated to Essentia Health. Essentia Health may use this information for treatment, payment, operations and case management purposes.

U. When consent is required under applicable state law, I authorize Essentia Health to access my current prescription history of regulated controlled substances in any applicable state databases (such as Minnesota's RxSentry PMP database).

V. I understand that this authorization ends one (1) year from the date signed except for purposes of payment and research.

W. If this is my first visit to this Essentia Health location, I acknowledge that a copy of the current Notice of Privacy Practices has been provided to me and is available to me via postings in the registration areas and on the website www.essentiahealth.org. I understand that I can ask for a copy of the notice at any time.

- I understand that I may revoke this permission at any time by notifying Essentia Health in writing. No further release will take place after the date notified.
- I understand that other parties may use or disclose health information received from Essentia Health.
- I understand that Essentia Health will treat me whether or not I consent to sections L-M and O-S of this document.
- I understand I will receive a copy of this form.
- For care provided in Wisconsin: I understand Wisconsin law gives me the right to inspect and receive a copy of behavioral health and chemical dependency information to be disclosed.

If I am signing as Authorized Representative of the patient, I am:

☐ Parent of a minor ☐ Court appointed guardian/conservator ☐ Other:_____
(Please specify relationship to patient)

_____ ____/____/____ _____
Signature (Patient or Authorized Representative) Date Time

_____
Witness (signature by mark must be witnessed)

_____
Patient Name & Medical Record Number
OR
Patient Label

FOR ESSENTIA HEALTH USE ONLY - IF WRITTEN CONSENT COULD NOT BE OBTAINED AND VERBAL CONSENT MUST BE OBTAINED.

1. Essentia Health Employees will inform the parent/guardian that Essentia Health needs their *verbal consent* for Essentia Health to: (1) release their information for treatment, payment, and operations purposes; assign their benefits; contact their cellular phone; and acknowledge the Patient Bill of Rights and Notice of Privacy Practices information.
2. The parent/guardian should have an opportunity to review the information in the GCA before the Employee asks for their verbal consent. The Employee should ask the patient if they received a copy of the GCA by email, and if not, would they like to. Alternatively, the Employee may direct the patient to the Essentia Health website where the GCA is posted and ask the patient if they would like an opportunity to read it before consenting.
3. Essentia Health Employees will ask the parent/guardian if they are willing to give their verbal consent to the GCA then document that consent below.

The parent/guardian of the following patient was offered a copy of the GCA and verbally provided their consent to the terms of the GCA:

Patient Name (print):_____ Patient DOB: _____

Patient Medical Record Number: _____ Parent/Guardian Name: _____

Date Verbal Consent Provided: _____ Time Verbal Consent Provided: _____

Signature of Witness: _____ Printed Name of Witness: _____

Phone number of parent/guardian that was called: _____