COVID-19 Responsible Party Consent Form

1125 NE 99th Ave. Portland, OR 97220
Phone (503) 254-7383 Fax (503) 254-4568

Resident or Patient Information

Last Name | First Name | Date of Birth | Gender

Address | City | State | Zip | SSN* (or driver's license)

Primary Care Provider (PCP) Name | PCP Phone Number | PCP Fax Number

PCP Address | City | State | Zip

SSN and state of residence, or state identification/driver's license is needed to verify patient eligibility. If a SSN and state of residence, or state identification/driver's license is not submitted, the patient will need to attest that you attempted to capture this information before submitting a claim and the patient did not have this information at the time of service, or that you did not have direct contact with the patient and thus did not have an opportunity to attempt to capture this information. Claims submitted without a SSN and state of residence, or state identification/driver's license may take longer to verify for patient eligibility.

CONSENT FOR SERVICES: I have been provided or can request the Vaccine Information Sheet(s) corresponding to the vaccine(s) that the individual listed above will receive. I have read the information provided about the vaccine they are about to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand the individual stated above should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if they experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to the individual named above for whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize Gateway Medical Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that Gateway Medical Pharmacy may be required to or may voluntarily disclose health information to the physician responsible for this protocol of specific health information of people vaccinated at Gateway Medical Pharmacy (if applicable), a Primary Care Physician (if they have one), insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that Gateway Medical Pharmacy will use and disclose this health information as set forth in the Gateway Medical Pharmacy Notice of Privacy Practices (copy is available by requesting a paper copy from the pharmacy).

Vaccine Clinics: If receiving a vaccine through a vaccine clinic, I understand that their name, vaccine appointment date and time will be provided to the clinic coordinator.

If you are legally responsible for the resident listed above, please provide the following:

Name of Responsible Party or Power of Attorney | Relationship | Date

Signature of Responsible Party or Power of Attorney | Phone Number