William Ashnault RPh.-Owner
Thomas Cassio Jr.-Owner

Sandy Cassio- Owner
Linda Wang Pharm.D.

Twin City Pharmacy & Surgical
1708 Park Ave
South Plainfield, NJ 07080
Tel. (908) 755-7696 Fax. (908) 755-6003
Major Medical & Medicare Billing Available *
Oxygen * Hospital Beds * Wheelchairs * Walkers
Diabetic, Surgical & Ostomy Supplies

ACHC Accredited

IMMUNIZATION CONSENT FORM

Attach patient label here…

MEDICARE # _____

First Name: **Middle Initial:**

Last Name:

Address:

City: **State:** **Zip:**

Phone: – – **Birthdate:** M M D D Y Y Y Y **Age:** **Sex: (M/F)**

I, the undersigned, authorize the Twin City Pharmacy & Surgical, to administer the vaccine listed above to me or the person named below for whom I am the legal guardian. I have read the Vaccine Information Statement provided and understand the benefits and risks associated with the vaccine.

If you have ever experienced *adverse reactions* to immunizations, consult your doctor to discuss whether the vaccination is appropriate.

☐ SEND a copy of the vaccine record to the primary care provider. _____

☐ DO NOT SEND a copy of the vaccine record to the primary care provider.

CONSENT FOR SERVICES, MEDICAL RECORDS and HIPAA PRIVACY INFORMATION

I have read the adverse reactions associated with vaccine(s) to be administered. A copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result. My medical record may be shared with my physician/insurance. I am requesting that the immunization(s) be given to me or the person named below for whom I am the legal guardian. I, for myself, my heirs, executors, personal representatives and assigns, hereby release Twin City Pharmacy & Surgical, any retail site, grocery store, pharmacy, corporation, physician and/or medical director and their respective affiliates, subsidiaries, divisions, directors, contractors, agents and employees, from any and all claims arising out of, in connection with or in any way related to my receipt of this or these immunization(s). Twin City Pharmacy & Surgical and the other aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. Twin City Pharmacy & Surgical will use and disclose your personal and health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY AND CONFIDENTIALITY PRACTICES** to help you better understand our policies in regards to your personal health information. I acknowledge that I have received a copy of the Notice of Privacy and Confidentiality Practices. I agree to remain in the general area for at least 15 minutes after receiving the vaccine.

x _____ _____
Signature/Legal Guardian — Date of Service

_____ _____
Print name — Pharmacist's Signature