

**SECTION F: OFFICE OF PRIVACY AND SECURITY
Authorization for Disclosure of Protected Health Information**

As the person signing this authorization, I understand that I am giving permission to the Virginia Department of Health (VDH) to disclose personal health information to the person(s) or organization(s) indicated below.

- I understand the provision of treatment to my child cannot be conditioned on my signing of this Authorization for Disclosure Section.
- Any health information re-disclosed by you will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included in my child's medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my child's medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my child's medical records.
- I authorize VDH to disclose my child's health information to the child's primary care physician and school.
- I understand that this record will be retained for ten years after the last visit or for five years after age 18, whichever comes later.
- I understand this document will be given to and retained by the public health department and will not be maintained by the school.

**SECTION G: NOTICE OF DEEMED CONSENT
(Required by §32.1-45.1 of the Code of Virginia (1950), as amended)**

If the health care provider or the person acting under the health care provider's direction and control is directly exposed to my child's blood in a way that may transmit disease, I understand that the law requires my child to give a venous blood sample for further tests. I understand that the tests to be performed are for human immunodeficiency virus (HIV), hepatitis and/or other infectious diseases and that a physician or health care provider will inform me and the exposed provider of the results of the test.

I understand that the Virginia Department of Health will not release private medical records unless authorized above or to continue care.

Please Print Your Name
(parent or legal guardian)

Signature

Date

This form must be returned prior to, or on the date of your child's H1N1 Flu Clinic

HEALTH DEPARTMENT USE ONLY

Date Dose Administered	Item code	Does Number (1 st or 2 nd)	Vaccine Manufacturer	Lot Number	Vaccine Administration Site	Provider #
	2009 H1N1				RA LA NAS	
	2009 H1N1				RA LA NAS	

Comments: (Enter reason if vaccine not administered)