STAMFORD HEALTH

Insert Medical Record or ID here

Authorized Representative Consent for COVID-19 Vaccination

Patient's Name:	**Date of Birth:**
Authorized Representative's Signature:	**Relationship:**
Name of Person Accompanying Minor:	**Relationship:**
Print Last Name:	**Print First Name, Middle Initial**
State:	**County:**
Date:	**Time:**

I have read or had explained to me the information concerning the safety and efficacy of the COVID-19 vaccine, which has been made available to me through the State of Connecticut's official website (Connecticut COVID 19 Response) and understand the risks and benefits. 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 from the receipt of the immunizations(s) by the person named below for whom I am the legal guardian ("Ward.") The medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to my Ward. I, on behalf of my Ward and each of our respective heirs, executors, personal representatives, and assigns, hereby release the provisioning mass vaccination center, Stamford Health Inc., and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties,") from any and all claims arising out of, in connection with or in any way related to the receipt of my Ward of this or these immunization(s). Neither the provisioning mass vaccination center nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or 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. The provisioning vaccination center will use and disclose the personal and health information of your Ward, to treat your Ward, to receive payment of the care we provide, and for other healthcare operations. Healthcare operations generally include those activities we perform to improve the quality of care. In the event that another family member, caregiver or other authorized person accompanies my Ward for the vaccination, I hereby authorize Stamford Health to administer the vaccine to my Ward and, in the course of doing so, disclose any protected health information concerning my Ward to such authorized person that may be necessary for such administration.