Authorization for Immunization Proxy of Minor

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An immunization proxy is a person who is authorized by the legal parent or guardian to bring child/children in for scheduled immunizations as recommended and/or required by the CDC. The designated proxy must be at least the legal age of 18 and must present legal identification at the time of vaccination.

I, _____, (legal parent or guardian) hereby authorize

the designated proxy, _____to bring the designated child/children listed below:

First and Last Name	Date of Birth

to the Brown County Health Department to receive immunizations as outlined in accordance with the schedule of immunizations required and/or recommended by the CDC and supported by the standing orders signed by the medical director of Brown County Health Department.

This proxy designation is valid from the date of signature_____ until the date it is rescinded by the Parent/Guardian or until the child/children reach the age of 18 years.

I understand that I have the right to revoke this authorization by giving written notice to the health department. If I refuse to sign this authorization, the above–described authorization will not be allowed except as provided by law.

I understand that this authorization for designated proxy is voluntary, and the health department may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization unless I am to receive health care solely for the purpose of creating protected health information to be disclosed to a third party or as otherwise authorized by law.
I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that this authorization is valid until the date of expiration stated above, or until I revoke it in writing by delivering a written revocation the health department.

I understand the nature and consequences of receiving services and they will be explained to me. I understand the health department is already authorized to use the information gained during treatment to bill me or any other potential source of reimbursement, such as government programs in which I am enrolled or qualified services. I also hereby acknowledge that I may receive a copy of the "Joint Notice of Privacy Practices" upon request by the health department.

I have a right to inspect and copy the information contained in my designated record set. I am entitled to a copy of this authorization if the health department is seeking this authorization.

Signature: _____ Date: _____

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Identity of person making request for Proxy of Minor was verified by: ☐ Driver's License ☐ Birth Certificate.

Check if any of the following apply:

☐ Parent or Guardian of minor ☐ Guardian with power to make health care decisions.

☐ Power of Attorney for Health Care ☐ Mental Health Treatment Preference Declaration Agent ☐ Health Care Surrogate

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