Signature on File and Medical Release
Statement to Permit Payment of Medicare/Medicaid Benefits to Provider

Recipient Name:_____

Address_____

Phone_____ D.O.B._____

Insurance ID#:_____

I request that payment of authorized Medicare, Medicaid or insurance benefits be made on my behalf to:

First Health Pharmacy
1300 Sunset Drive • Suite C
Grenada, MS 38901
662.226.0666

Medical Information Release

I authorize any holder of medical or other information about me to release to Medicare or Medicaid, the fiscal agents, or this provider any information needed to determine these benefits or the benefits payable for related services.
This authorization is valid for my lifetime.

Recipient's Signature_____ Date_____

Influenza Questionnaire

1. Have you ever had a reaction to the influenza vaccine?	No_____	Yes_____
2. Do you have an allergy to eggs?	No_____	Yes_____
3. Are you sick today or do you have fever today?	No_____	Yes_____
4. Are you pregnant in the first trimester?	No_____	Yes_____

Influenza Vaccine Consent

I have read and understand the influenza vaccine information sheet. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that it be given to me, or to the person named below for whom I am legally authorized to make this request. I, hereby, release First Health Pharmacy and/or the person administering the vaccine to me, from any all liability related to this vaccine.

Name_____ Signature_____

(Place pharmacy label here)

Injection location=Deltoid L___ R___ Signature of person giving injection_____