



CONSENT

**MUSC, Hollings Cancer Center Mobile HPV Vaccination Van
Consent for Treatment**

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Form Origination Date: 2/2022
Version: 1

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Patient Name _____

MRN _____
PATIENT IDENTIFICATION LABEL

I, as patient, guardian, parent, guarantor or other responsible party consent to and authorize medical treatment from the MUSC Hollings Cancer Center Mobile HPV Vaccination Van. I allow the designated healthcare professional to provide vaccine(s) checked below to me or the person named below for whom I am authorized to make this request, and to bill for this service (if insured).

I authorize the holder of medical or other information about me or the person named below for whom I am authorized to give consent, to release to any other third party responsible for payment such as information needed for decisions of Medicare, Medicaid, or third-party claims.

I acknowledge that I will be responsible for any payments not covered by my health plan, to include deductibles. I understand this consent form is valid until I revoke it.

I received a copy of a "Notice of Privacy Practices" from providers who are authorized by my child's school district and/or a copy of the MUSC "Notice of Privacy Practices".

☐ HPV ☐ Tdap ☐ Polio ☐ Meningitis ☐ MMR ☐ Varicella ☐ HepA

Signature of Patient or Legal Guardian/Representative
(or Student if 16 years or older or otherwise permitted by law)

Date

Printed Name Patient or Legal Guardian/Representative
(or Student if 16 years or older or otherwise permitted by law)

Date

Relationship to Patient

Witness Signature