STORE # ADDRESS

CITY, STATE, ZIP PHONE

Vaccine Consent and Administration Record

Pharmacist Immunization Program

Information about patient receiving vaccine (Please print):

LAST NAME | FIRST NAME | MIDDLE INITIAL | DATE OF BIRTH | GENDER M/F

STREET | CITY | STATE | ZIP | PHONE

MEDICAL CONDITION(S) | ALLERGIES

PRIMARY CARE PHYSICIAN (PCP) | PCP CONTACT INFORMATION

Precautions and Contraindications – please answer each question and check Yes or No	**Yes**	**No**
1. Do you have a sensitivity to latex?	☐	☐
2. Are you allergic to chicken eggs and/or egg products?	☐	☐
3. Are you allergic to gelatin, neomycin or any other component of a vaccine?	☐	☐
4. Are you allergic to thimerosal (used as a preservative in vaccines)?	☐	☐
5. Have you had a seizure, brain, or other nervous system problem (Guillain-Barre Syndrome, etc.)?	☐	☐
6. Are you sick or do you have any symptoms other than mild coughing, runny nose or diarrhea?	☐	☐
7. Have you ever had a serious reaction after receiving a vaccination?	☐	☐

CONTACT YOUR PHYSICIAN OR HEALTH CARE PROVIDER BEFORE RECEIVING THIS VACCINE IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS

8. Do you take anticoagulant medication (Warfarin, Coumadin, Lovenox, other blood thinners)?	☐	☐
9. Do you take cortisone, prednisone, other steroids, or anti-cancer drugs?	☐	☐
10. Are you receiving radiation treatments, or do you have cancer, leukemia, AIDS or another immune system disorder?	☐	☐
11. Do you have a heart disease, lung disease, asthma, kidney disease, diabetes, anemia or other blood disorder?	☐	☐
12. Have you received any vaccinations in the past 4 weeks?	☐	☐
13. Do you have tuberculosis?	☐	☐
14. FOR WOMEN – Are you pregnant or nursing?	☐	☐

Please sign and complete the back of the vaccine consent form.

Please read the following statements and sign on the signature line below.

Consent for Services, Medical Records and HIPAA Privacy Information
I have been provided with the Vaccine Information Sheet corresponding to the vaccine(s) that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named above for whom I am authorized to make the request. I, for myself, my heirs, executors, personal representatives and assigned, hereby release TOPS Markets, LLC and their representative affiliates, subsidiaries, divisions, directors, contractors, agents and employees, from any and all claims including any loss, injury, death or damage suffered that is arising out of, in connection with or in any way related to my receipt of this or these immunization(s).

I voluntarily authorize and direct my pharmacist at TOPS Markets, LLC to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at TOPS Markets, LLC (standing order provider _____), my Primary Care Provider (PCP), my insurance plan and/or state or federal registries, where required for purposes of treatment, payment or other health care operations (such as administration or quality assurance). This authorization permits TOPS Markets, LLC to disclose the following medical records: only documents related to the vaccination(s) received today. This Authorization will remain in effect until my pharmacist discloses my health information to the recipient identified above; my pharmacist cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such a refusal or revocation will not affect the commencement, continuation or quality of my treatment by my pharmacist. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider. The revocation will be effective immediately upon my pharmacist's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it receiving my written notice of revocation. I acknowledge that I have received the TOPS Markets, LLC Notice of Privacy Practices, which is provided on the back of the Patient copy of this consent form.

Medicare Billing: I do hereby authorize TOPS Markets, LLC to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this payment. I request that the payment of authorized benefits be made on my behalf.

X _____ **Date** _____

Signature of patient to receive vaccine or person authorized to make the request (parent/guardian)

This section to be completed by Pharmacy:

Vaccine Administration Information:

Date	Product	Manufacturer	Lot #	Exp. Date
Date	Admin Site	Dose (ml)	Administrator Name	

Patient Insurance Information:

Primary	
Plan Name	Bin #
ID #	Group #
Secondary (if applicable)	
Plan Name	Bin #
ID #	Group #

AFFIX LABEL HERE

Copies: White-TOPS Store Yellow—Primary Care Provider Pink--Patient

TOPS MARKETS LLC
NOTICE OF PRIVACY PRACTICES
Effective Date: April 14, 2003
(Revised April 21, 2005)

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

TOPS Markets LLC and their affiliates have a firm and long-standing commitment to protecting our customers' privacy. This Notice describes the privacy protections in place for our pharmacy-related services. Throughout this Notice, we use the term "Pharmacy" to refer to the health care components of TOPS Markets LLC, including TOPS Pharmacy and Martin's Pharmacy. Whenever you visit or receive services from one of our Pharmacy locations, you can expect the privacy of your health information to be protected as described in this Notice.

We are required by law to maintain the privacy of your health information, to provide you this detailed Notice of our legal duties and privacy practices relating to your health information and to abide by the terms of the Notice that currently is in effect.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Uses and disclosures of health information for treatment, payment and health care operations are permitted by the federal Privacy Rule and authorized by the signature log you sign at the pharmacies. The following lists various ways in which we may use or disclose your Protected Health Information ("PHI") for these purposes.

For Treatment. We will use and disclose your PHI in providing you with Pharmacy services and may disclose information to other providers involved in your care. For example, our Pharmacy associates will use your health information to dispense prescription medications to you in accordance with your provider's orders. We may contact your provider to discuss your prescription, possible drug interactions or other concerns.

For Payment. We may use and disclose your PHI for our billing and payment purposes, or for the billing and payment needs of another health care provider. We may disclose your health information to your representative, or to an insurance or managed care company, Medicare, Medicaid, another third-party payer, or another health care entity. For example, we may contact your health plan to confirm your coverage for certain prescription medications or the amount of your co-payment.

For Health Care Operations. We may use and disclose your PHI as necessary for our health care operations, such as management, personnel evaluation, education and training. For example, we may use and disclose your PHI to review the quality of our services.

Prescription Reminders. We may use or disclose PHI to remind you that your prescriptions are ready to be picked up at the Pharmacy or that it is time for you to refill your prescription.

Treatment Alternatives and Health-Related Benefits and Services. We may use or disclose your PHI to inform you about treatment alternatives and health-related benefits and services that may be of interest to you. We will not sell lists of pharmacy customers or other PHI to third parties for marketing purposes, however.

II. SPECIFIC USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The following lists various ways in which we may use or disclose your PHI.

To the Patient or their Personal Representative for their own use. On request, we will disclose your PHI to you or your Personal Representative (a person who is authorized by law to act on your behalf with respect to health care matters).

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose PHI about you to a family member, close personal friend or other person who is involved in your care or payment for your care, or we may disclose PHI to notify a family member about your general condition or location. Unless a family member has legal authority to act on your behalf, we will only disclose information relevant to that family member's involvement in your care.

As Required By Law. We may use or disclose your PHI when required by law to do so.

Health Oversight Activities. We may disclose your PHI to a health oversight agency, such as the Board of Pharmacy, for activities authorized or required by law, such as audits, investigations and inspections or for activities involving government oversight of the health care system.

Business Associates. We may disclose your protected health information to a contractor or service provider (known as a "business associate") that needs the information in order to perform services for the Pharmacy and that agrees to protect the confidentiality of this information.

III. PERMITTED DISCLOSURES OF YOUR HEALTH INFORMATION

In addition to the disclosures described above, we may make the following disclosures, subject to conditions and limits in federal and state law. Note: in some circumstances disclosures listed below may be required by law, and so also covered in Section II above.

Public Health Activities. We may disclose your PHI to a public health authority charged with, for example, preventing or controlling disease, injury or disability.

Reporting Victims of Abuse, Neglect or Domestic Violence. If we believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your PHI to notify a government authority, if authorized by law or if you agree to the report.

To Avert a Serious Threat to Health or Safety. When necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person, we may use or disclose PHI, limiting disclosures to someone able to help lessen or prevent the threatened harm.

Judicial and Administrative Proceedings. We may disclose your PHI in response to a court or administrative order. We also may disclose information in response to a subpoena, discovery request, or other lawful process; efforts must be made to contact you about the request or to obtain an order or agreement protecting the information.

Law Enforcement. We may disclose your PHI for certain law enforcement purposes, including, for example, to comply with reporting requirements; to comply with a court order, warrant, or similar legal process; or to answer certain requests for information concerning crimes.

Research. We may use or disclose your PHI for research purposes if the privacy aspects of the research have been reviewed and approved, if the researcher is collecting information in preparing a research proposal, if the research occurs after your death, or if you authorize the use or disclosure.

Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations. We may release your PHI to a coroner, medical examiner, and funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

Disaster Relief. We may disclose limited PHI about you to a disaster relief organization.

Military, Veterans and other Specific Government Functions. If you are a member of the armed forces, we may use and disclose your PHI as required by military command authorities. We may disclose health information for national security purposes or as needed to protect the President of the United States or certain other officials or to conduct certain special investigations.

Workers' Compensation. We may use or disclose your PHI to comply with laws relating to workers' compensation or similar programs.

Inmates/Law Enforcement Custody. If you are under the custody of a law enforcement official or a correctional institution, we may disclose your PHI to the institution or official for certain purposes including the health and safety of you and others.

IV. USES AND DISCLOSURES WITH YOUR AUTHORIZATION

Except as described in this Notice, we will use and disclose your health information only with your written Authorization. You may revoke an Authorization in writing at any time. If you revoke an Authorization, we will no longer use or disclose your health information for the purposes covered by that Authorization, except where we have already relied on the Authorization.

V. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Listed below are your rights regarding your health information. Each of these rights is subject to certain requirements, limitations and exceptions. Exercise of these rights may require submitting a written request to the Pharmacy. At your request, the Pharmacy will supply you with the appropriate form to complete. You have the right to:

Request Restrictions. You have the right to request restrictions on our use or disclosure of your health information for treatment, payment, or health care operations. You also have the right to request restrictions on the health information we disclose about you to a family member, friend or other person who is involved in your care or the payment for your care.

We are not required to agree to your requested restriction (except that if you are mentally competent, you may restrict disclosures to family members or friends). If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you emergency treatment or in accordance with federal and state law.

Access to Personal Health Information. You have the right to inspect and obtain a copy of your clinical or billing records or other written information that may be used to make decisions about your care, subject to some exceptions. Your request must be made in writing. In most cases we may charge a reasonable fee for our costs in copying and mailing your requested information.

We may deny your request to inspect or receive copies in certain circumstances. If you are denied access to health information, in some cases you have a right to request review of the denial. This review would be performed by a licensed health care professional who did not participate in the decision to deny.

- **Note: requests at the Pharmacy for copies of your prescription records, such as for tax submission purposes, are not treated as formal Requests for Access and are handled directly by the Pharmacy. If you wish to exercise your right to access your PHI, you should ask the pharmacist for a special "HIPAA Request for Access" form.**

Request Amendment. You have the right to request amendment of your health information maintained by the Pharmacy for as long as the information is kept by or for the Pharmacy. Your request must be made in writing and must state the reason for the requested amendment.

We may deny your request for amendment if the information (a) was not created by the Pharmacy, unless the originator of the information is no longer available to act on your request; (b) is not part of the health information maintained by or for the Pharmacy; (c) is not part of the information to which you have a right of access; or (d) is already accurate and complete, as determined by the Pharmacy.

If we deny your request for amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial.

- **Note: simple requests at the Pharmacy, such as changing your address or insurance information, are not treated as formal Requests for Amendment and are handled directly by the Pharmacy. If you wish to exercise your right to request amendments to your PHI, you should ask the pharmacist for a special HIPAA Request for Amendment" form.**

Request an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your health information. This is a listing of disclosures made by the Pharmacy or by others on our behalf, but does not include disclosures for treatment, payment and health care operations, disclosure made pursuant to your Authorization, and certain other exceptions.

To request an accounting of disclosures, you should ask the pharmacist for a special "HIPAA Request for Accounting" form, stating the time period in question and listing the locations of all pharmacies for which you are requesting an accounting. The first accounting provided within a 12-month period will be free; for further requests, we may charge you our costs.

Request Confidential Communications by Alternative Means. You have the right to request that we communicate with you concerning your health matters in a certain manner. We will accommodate your reasonable requests.

- **Note: simple requests at the Pharmacy, such as calling a patient at an alternate location when a prescription is ready, are not treated as formal Requests for Confidential Communications and are handled directly by the Pharmacy. If you wish to exercise your right to request confidential communications by alternative means, you should ask the pharmacist for a special "HIPAA Request for Confidential Communications" form.**

Request a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. **In addition, you may obtain a copy of this Notice at our website, www.TopsMarkets.com.**

State Law Privacy Protections. In New York, Ohio, and Pennsylvania, we may not disclose certain confidential HIV or AIDS information about an individual except with the individual's written authorization or when authorized or required by state or federal law. In Pennsylvania, we may not disclose certain confidential information relating to an individual who is obtaining or has obtained treatment for drug or alcohol abuse or dependence, except with the individual's written authorization or when authorized or required by state or federal law.

VI. FOR FURTHER INFORMATION OR TO FILE A COMPLAINT

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact the Pharmacy Privacy Representative at 716-635-5000.

If you believe that your privacy rights have been violated, you may file a complaint in writing with the Pharmacy or with the Office of Civil Rights in the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint.

To file a complaint with the Pharmacy, you may request a HIPAA Complaint Form at your store, or contact the Privacy Representative listed above.

VII. CHANGES TO THIS NOTICE

We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all health information already received and maintained by the Pharmacy as well as for all health information we receive in the future. We will provide a copy of the revised Notice upon request.

DISCLOSURES PERMITTED/PROHIBITED IN CERTAIN STATES

TOPS Markets LLC operates pharmacies in several states and complies with the applicable laws of each state. This page lists some of the general provisions of law in the states in which we operate. These laws contain certain conditions, and are subject to change and interpretation. Generally, all states permit uses and disclosures in accordance with Sections I, II and IV of our Notice. Certain disclosures listed in Section III may be limited by state law, depending on the circumstances and the interpretation given to state law. In some states you also may have additional protections for certain specially protected categories of information. The applicability and interpretation of these state laws will vary depending on the particular law and the circumstances involved.

HIV: New York, Ohio, and Pennsylvania

We may not disclose certain confidential HIV or AIDS information about an individual, except with the individual's written authorization or when authorized or required by state or federal law.

Substance abuse: Pennsylvania

We may not disclose certain confidential information relating to an individual who is obtaining or has obtained treatment for drug or alcohol abuse or dependence, except with the individual's written authorization or when authorized or required by state or federal law.

Acknowledgment of Receipt of Notice of Privacy Practices

If you did not provide your signature acknowledging receipt of this Notice at the Pharmacy, please complete the section below, tear off this portion and return it to the Pharmacy from which you obtained your prescription:

By signing below, I acknowledge that I have received a copy of the TOPS Pharmacy's Notice of Privacy Practices:

Name of Customer (print) Signature Date

Pharmacy Name / Address Prescription Number

If signed by the patient's Personal Representative, please print your name and describe your relationship to the customer or other authority to act:

Print Name of Personal Representative Relationship to patient