Nez Perce Tribe
COVID-19 Vaccination Incentive

Questions?
Patient Care Coordinator
Nimiipuu Health
208-843-2271

Full Name:_____

Enrollment #:_____ Date of Birth:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Phone #:_____ Email:_____

Vaccination Site Name & Phone #:_____

EMPLOYEES ONLY:
Tribal Entity:_____ Employee #:_____

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Authorization to Disclose Healthcare Information

I, _____, authorize medical information to be released to the Nimiipuu Health Clinic or in the alternative from an outside clinic or other vaccination facility for the purpose of verifying my/my dependent's COVID-19 vaccination status. I also authorize the release of necessary medical information by Nimiipuu Health in order to process my incentive payment and to have my name entered into the vaccine incentive lottery drawings.

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire six (6) months from the date of my signature. I understand that once the above information has been disclosed, it may be re-disclosed by the recipient and the information may be protected by federal privacy laws or regulations.

I further understand that authorizing the use or disclosure of the information identified above is voluntary.

◯ **I do not wish to participate in the COVID-19 Vaccine Lottery Incentive**

_____ _____
Signature (Parent/Guardian, if under 18) Date

Return completed form AND copy of COVID-19 vaccination certificate to:
covid19incentive@nimiipuu.org or fax to 208-843-2658, or mail to: Patient Care Coordinator, Nimiipuu Health, P.O. Drawer 367, Lapwai, ID 83540.