

American Samoa Government

Request for Vaccine Waiver for Medical Reasons and HIPAA Waiver

Name: _____ Date of Birth: _____

Email: _____ Phone #: _____

Planned Travel Date: _____ Carrier: _____

Request for waiver of the vaccine requirement to enter American Samoa for medical reasons:

1. What medical condition do you have that prevents you from received a COVID-19 Vaccination.

2. Please provide documentation of your medical condition

3. The American Samoa Department of Health may need to confirm your health information. Please complete the Medical Records Request and HIPAA Authorization to Disclose Medical Records

- **What information is to be disclosed:** Medical Records. I further authorize the provider listed below to discuss medical conditions that affect my ability to safely receive COVID vaccinations.
- And discussions may be limited to Limit the records to this date range: _____
- Who may receive the information: American Samoa Department of Health
Recipient
- This authorization is for the disclosure of health records in the possession of the

Provider Phone Number

- Purpose: This disclosure is at the request of the individual
- Expiration: This authorization expires 60 days after the signature date unless otherwise stated.
- Statements required by HIPAA - 45 C.F.R. § 164.508(c)(2)
 - I have the right to revoke this authorization in writing by notifying the provider and the notifying the authorized recipient in writing.
 - ASG nor any other entity may require a patient to sign this authorization in order to receive treatment or be eligible for benefits.
 - The information released to the recipient may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature Date

Scan and email the completed document along with any attachments to covidtravel@go.as.gov.