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New Patient Registration Form

Today's Date_______________

Last Name_____________________ First Name________________________ Date of Birth______________

Nickname______________________ ☐Male ☐Female

Mother/Guardian Name_____________________________________ DOB_____/_____/______

Address_____________________________________City___________________State_____ZIP_____________

Home ph_______________________cell ph______________________ work ph_____________________

Email______________________________Employer____

Father/Guardian Name______________________________________ DOB_____/_____/______

Address_____________________________________City___________________State_____ZIP_____________

Home ph_______________________cell ph______________________ work ph_____________________

Email______________________________Employer____

Who does patient live with? MOTHER FATHER BOTH GUARDIAN

NOTE: If parents are divorced or living separately, please provide copies of custody papers at FIRST visit

Primary Insurance Company ____________________ID number _________________Group Number____________

Insurance phone number _____________________

Subscriber's name________________________________ Subscriber's DOB_________________________

Subscriber's relationship to patient____

Secondary Insurance Company__________________ ID number _________________Group Number____________

Insurance phone number _____________________

Subscriber's name________________________________ Subscriber's DOB_________________________

Subscriber's relationship to patient____

Preferred Pharmacy___________________________ **Pharmacy phone number**______________________

Medicaid Waiver

Continuum Pediatrics will NOT ACCEPT Medicaid of Texas as primary or secondary insurance.

I _________________________________ (patient's guardian) have read, understand, and agree to the above policy by Continuum Pediatrics. I will be responsible for any non-covered services not covered by my health insurance plan(s).

This waiver is valid for all dates of service. All patients must complete & sign this form even if you have no intention of using Medicaid as a form of payment.

____

Parent/Guardian's Signature

_____________________________________ __________________________________

Relationship to Patient Date

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Consent for Treatment Authorization

Patient Name ____ Date of Birth ___________________________

Parent/Guardian's Printed name ______________________________

I hereby authorize the following person(s) to seek medical care and make decision in relation to advice rendered at Continuum Pediatrics and/or its employees in my absence:

________________________________	____________________	_______________________________	___________________
Printed Name	Relationship to Patient	Printed Name	Relationship to Patient
________________________________	____________________	_______________________________	___________________
Printed Name	Relationship to Patient	Printed Name	Relationship to Patient

This authorization shall remain in effect from today's date for a period of one year, sooner if revoked in writing or if any changes.

Assignment of Benefits

Financial responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our billing office. Necessary forms will be completed to file for insurance carrier payments.

If the child has multiple carriers it is solely the parent/guardian's responsibility to inform this office. Should any claims be denied of payment for this reason and our office has not been aware, payment of all denied claims will become the responsibility of the parent/guardian.

There may be times when a "well" visit will be changed to a "sick" visit based on diagnosis during your evaluation by the physician. Your insurance company may require you to pay additional coinsurance or fees at the time of service. Please check with your insurance carrier about your specific benefits.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier to issue payment checks directly to Continuum Internal Medicine and Pediatrics, a division of Texas Digestive Disease Consultants, for medical services rendered to myself and or my dependents regardless of my insurance benefits, if any. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY THE INSURANCE.

Authorization to release information

I hereby authorize Continuum Internal Medicine and Pediatrics to 1) release any information necessary to insurance carriers regarding my illness and treatments (2) process insurance claims generated in the course of examination and treatments; (3) allow a photocopy of my signature to be used in the process of insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from on behalf of myself and or my dependents, and I understand that by making this request, I BECOME FULLY FINANCIALLY REPONSIBLE FOR ANY AND ALL CHARGES INCURRED IN THE COURSE OF THE TREATMENT AUTHORIZED.

I FURTHER UNDERSTAND THAT FEES ARE DUE AND PAYABLE AT THE TIME THAT SERVICES ARE RENDERED, AND I AGREE TO PAY ALL SUCH CHARGES INCURRED IN FULL IMMEDIATELY UPON PRESENTATION OF THE APPROPRIATE STATEMENT. A photocopy of this assignment is to be considered as valid as the original.

____

Parent/Guardian's Signature

_____________________________________ ___________________________________

Relationship to Patient Date

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Office Policies

Vaccine Policy:

______I have read the enclosed vaccine policy and intend to vaccinate my child according to the most current guidelines set forth by the American Academy of Pediatrics and the US Centers for Disease Control.

After Hour Calls:

______Our office hours are Monday through Friday 8:00am to 5:00pm. We make every effort to return patient calls promptly, usually by the end of the business day. After hour calls are defined as calls received after 5:00pm Monday-Friday and all weekends or holidays. These calls will accrue a **$35.00** ***after hours call fee*** applied to your account. This fee cannot be billed to your insurance company.

No Show Policy:

______We ask you to be considerate of the medical needs of others and call our office promptly within 24 hours of your appointment if you are unable to make your appointment time. This allows us to make your appointment available to another patient who needs medical attention.

If you do not arrive for your appointment, or fail to cancel prior to 24 hours before your appointment time, there will be a **$25.00** ***no show fee*** applied to your account that will need to be paid in full by the next scheduled appointment time. This fee cannot be billed to your insurance company.

You may be reminded of your upcoming appointment by portal reminder, text, or phone call. Please understand that these reminders regarding your appointment are a COURTESY only, any disputes regarding no shows because of a courtesy call or text "not received" will NOT be waived. You are ultimately responsible.

The doctors make every effort to be respectful of our patients' time and to see our patients on time. Please be aware that if you arrive **10 minutes** after your scheduled appointment time, you may be asked to reschedule.

Letters/Completion of Forms:

______Please bring any forms that require a doctor's approval to your appointment. Any requests for forms to be completed after an appointment will accrue a fee. This fee will be applied to your account and will not be covered by insurance. Please give our office 48 hours to complete any forms. Any letter that you request the physician to write also will incur a fee. This fee cannot be billed to your insurance company. Please contact the office staff for a list of fees for commonly requested forms.

Consent for Photography:

_______I hereby consent Continuum Pediatrics to photograph my child and an adult caregiver. The purpose is to document the identity of the patient and caregiver in the medical and billing records for the purpose of clinical care as well as collection of payments.

____________________________________ ____________________

Patient's Name (PRINT) Date

_____________________________________ ____

Parent's Name (PRINT) Parent's Signature

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Limited Patient Authorization for Disclosure of Protected Health Information **Form 7.31**
Please print all information. Form must be signed and dated each year.

Patient Name:____ **Date of Birth:** ______/____/______

Entity Requested to Release Information:
Continuum Internal Medicine & Pediatrics

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about the above minor patient to the individual(s) listed below.

Who will be authorized to receive information (list the individuals other than parent/guardians):

Individual Name: ____________________________________ Relationship to patient:__________________________________

Individual Name: ____________________________________ Relationship to patient:__________________________________

Individual Name: ____________________________________ Relationship to patient:__________________________________

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐Entire patient record; or, check only those items of the record to be disclosed:

- ☐Office notes
- ☐Immunization records
- ☐Lab results
- ☐Record of HIV and communicable disease testing
- ☐X-rays
- ☐Record of mental health or substance abuse treatment
- ☐Financial history report (previous 3 years only).

☐Only send the following: ____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐Patient Request ☐Other (please specify): ____

-This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: ________________________________
-You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
-The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
-We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

Parent/Guardian name(PRINT)____

Parent/guardian signature ____Date_______________________

You have the right to receive a copy of signed authorization upon request.

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New Patient Health History

Name_________________________________ **Date of Birth**___________________

Birth History:
Was your child born ☐full term ☐early
What was your child's weight at birth?_______ Any problems after birth?___________
Was your child delivered by☐ c-section ☐vaginally

Does your child have any chronic medical problems?

____

Does your child take any medications on a regular basis? If so, please list below.

____

Does your child have any allergies to medications?

____

Has your child ever been hospitalized overnight? (not ER visits)

____

Has your child ever had any surgeries? If so, please list below.

____

Tell us about your family:
Patient's Father : age ______ medical problems______________
Patient's Mother: age ______ medical problems______________
Patient's Brother(s): age ______ medical problems______________
Patients' Sister(s): age ______ medical problems______________

Do you have any forms that you would like the doctor to complete? YES NO

Do you have any concerns you would like to discuss with the doctor today?

____

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Vaccine Policy

* We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

* We firmly believe in the safety of our vaccines.

* We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.

* We firmly believe, based on all available literature, evidence, and current studies, that vaccines DO NOT cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.

* We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son Franky, who contracted smallpox and died at the age of 4, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

"In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox . . . I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen."

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even dis- cussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

After publication of an unfounded accusation (later retracted) that MMR vaccine caused autism in 1998, many people in Europe chose not to vaccinate their children. As a result of underimmunization, there were large outbreaks of measles, with several deaths from complications of the disease. In 2010 there were more than 3000 cases of whooping cough in California, with nine deaths in children less than six months of age. Again, many of those who contracted the illness (and then passed it on to the infants, who were too young to have been fully vaccinated) had made a conscious decision not to vaccinate.

Furthermore, by not vaccinating your child you are taking selfish advantage of thousands of others who do vaccinate their children, which decreases the likelihood that your child will contract one of these diseases. We feel such an attitude to be self-centered and unacceptable.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, should you have doubts, please discuss these with our office in advance of your visit **Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Continuum Pediatrics.** Such additional visits will require additional co-pays on your part. Furthermore, please realize that you will be required to sign a "Refusal to Vaccinate" acknowledgement in the event of lengthy delays.

All patients in the practice are required to receive a minimum of DTaP, Hib, polio, and pneumococcal vaccines by three months of age, all AAP-recommended immunizations by two years of age, and meningococcal vaccine and booster doses of Tdap and varicella vaccines by age 12 years.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults.

Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

From Dr. Kathryn Mandal and the Staff of Continuum

Continuum Internal Medicine and Pediatrics

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

(469) 930-3064

We will not retaliate against you for filing a complaint.

Effective Date 9/23/2013 Publication Date 9/23/2013

ImmTrac Frequently Asked Questions

Question: **What is ImmTrac?**
Answer: The official Texas immunization registry from the Texas Department of State Health Services (DSHS). It is a secure, confidential registry that stores immunization records electronically in one centralized system at no cost.

Question: **What are the benefits?**
Answer: You can safely store your immunization records in ImmTrac at no cost to you. Your records will be kept secure and confidential. Even if, you got one vaccine at your doctor's office and another at your local pharmacy, you can electronically store all your immunization records in ImmTrac. Then, you will have one immunization history. You can request a copy of your immunization history when you need it for college entrance requirements, military enlistment, travel, employment in health and safety fields, and other instances.

Your ImmTrac authorized health-care provider can access your immunization history and make sure you are not over or under vaccinated. This way, you will be fully protected against vaccine-preventable diseases and save money by not paying for vaccines you do not need.
ImmTrac offers many benefits:

- A NO COST SERVICE
- SECURE
- CONFIDENTIAL
- ELECTRONIC
- CENTRALIZED
- ACCESSIBLE TO AUTHORIZED HEALTH- CARE PROVIDERS

Question: **Who can be a part of ImmTrac?**
Answer: Anyone in Texas who would like to keep his or her immunization records in a secure and confidential electronic system can register.

Question: **What if I'm already registered in ImmTrac as a child?**
Answer: If your immunization records were in ImmTrac as a child, you can keep them in ImmTrac as an adult. You must sign an *ImmTrac Adult Consent Form* between your 18th and 19th birthday to continue to keep your record in ImmTrac. If you do not sign this form by your 19th birthday, your record will be deleted.

Question: **If an ImmTrac client's records were entered into ImmTrac by the client's parent as a child (age 17 and younger), will the client's immunization history be in ImmTrac for a lifetime?**
Answer: No, when an ImmTrac client turns 18 years old, the client is legally an adult. The client must sign an ImmTrac Adult Consent form in the time between the client's 18th and 19th birthday to keep the immunization records in ImmTrac that were entered in as a child in ImmTrac for a lifetime. If an ImmTrac client does not sign an ImmTrac Adult Consent

Form by the client's 19th birthday, the client's ImmTrac ID, including immunization records, will be deleted and cannot be recovered in ImmTrac.

Question: **If I've never registered in ImmTrac, how can I register?**
Answer: If you have never registered with ImmTrac, either as a child or as an adult, you can:

1. **Download** and complete the ImmTrac Adult Consent Form (F11-13366) from ImmTracForEveryone.com.

2. **Gather and make copies** of all your official immunization records.

3. **Send in** your completed ImmTrac Adult Consent Form and copies of your official immunization records to your authorized health-care provider, local health department (LHD), DSHS health service region (HSR) office **or** the Department of State Health Services ImmTrac office.

Question: **Do I have to be up to date on my vaccines to register?**
Answer: No. You do not have to be up to date with all your vaccines to register with ImmTrac. You may want to review the *Recommended Adult Immunization Schedule* with a health-care provider to determine which vaccines you still need. Even though you are a young adult, there are more recommended adult vaccines now then when you were a child. Go to www.Vaccinesforeveryone.com or www.ImmTrac4everyone.com to download the *Recommended Adult Immunization Schedule.*

Question: **How do I find out if I am already signed up for ImmTrac?**
Answer: Fill out and submit an Authorization to Release ImmTrac History form. ImmTrac will look in the registry and inform you if your records are part of the registry.

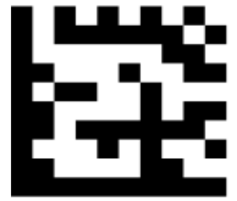
Question: **Who can access ImmTrac?**
Answer: An ImmTrac client can access ImmTrac by requesting a paper copy of your immunization record from an authorized health-care provider, local health department, health service region, or the Texas Department of State Health Services ImmTrac office. An ImmTrac client does not have direct access to the ImmTrac registry. Just like you cannot view your medical records online, you cannot view your ImmTrac records online either. This is to ensure the confidentiality and security of the immunization records.

Question: **Are all health-care providers part of the ImmTrac registry?**
Answer: No. Only health-care providers who are registered with ImmTrac are part of ImmTrac as an authorized provider. It is optional for all health- care providers to be a part of ImmTrac.

Question: **How do ImmTrac clients contact ImmTrac?**
Answer: The ImmTrac group can be contacted by:
Phone: 800- 252- 9152
Fax: 512-458- 7790
Email: ImmTrac@dshs.state.tx.us

IMMUNIZATION REGISTRY (ImmTrac2)

Minor Consent Form



(Please print clearly)

Child's Last Name

Child's First Name

Child's Middle Name

Child's Date of Birth

*Children younger than 18 years old only.

Child's Gender: ☐ **Male** ☐ **Female**

Child's Address

Apartment #

Telephone - -

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.
Parent, legal guardian, or managing conservator:

Printed Name

Date

Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

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Thanks for coming! How did you hear about us?

☐Former patient of Dr. Mandal

☐Facebook post

☐Internet search

☐Heard about her from a friend

☐Postcard mailed to your home

☐Another doctor referred you

☐Attended a community event

☐Other ____