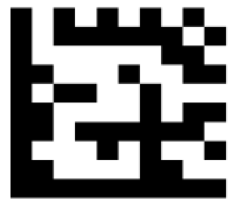


IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(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.**

220 E. Evergreen St.

Sherman, TX 75090

Phone: 903-202-2900

Fax: 903-202-2901

Parental Authorization for Treatment of a Minor

State of: ________________________________

County of: ________________________________

I, _____________________________, parent/guardian of _____________________________, a
Parent/Guardian Name Patient's Name

minor child born on _____/_____/_____ hereby authorize:

____________________________________ ____________________________________
Name of authorized individual/relation Name of authorized individual/relation

____________________________________ ____________________________________
Name of authorized individual/relation Name of authorized individual/relation

To give consent for the medical treatment of the above-named child for any condition that he/she may encounter and to give consent for all well child checkups, including vaccinations, at Texoma Physicians Group, PLLC. I also authorize the providers within the group to give information to the individual(s) named above regarding the diagnosis, plan of treatment and any information necessary for the care of the above-named child. I hereby release Texoma Physicians Group, PLLC of any liability regarding the release of this information on the above-named child.

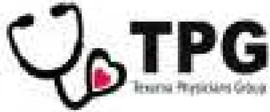
Optional: I hereby authorize my child (ages 16 years and up only) to receive medical treatment without an authorized person accompanying him/her. __________
Initial

Executed this __________ day of __________, 20_____.

____
PRINT – Parent/Guardian Name

____
SIGNATURE – Parent/Guardian Name

T



Pediatric and Adolescent Medicine
Patient Registration Form

PATIENT INFORMATION (Please Print ONLY)

Patient's Last Name:	First Name:	M.I.:	Birth Date: – –	Age: ____ Sex: ··· Male ··· Female Social Security No.: / /

Street Address:	City:	State:	ZIP:	Home Phone No.: ( ) –

Other family members treated here:

PARENT(S) / LEGAL GUARDIAN INFORMATION

Mother's Last Name:	First Name:	M.I.:	Birth Date: – –	Social Security No.: / /

Street Address: (or same as above)	Home Phone No.: ( ) –	Work Phone No.: ( ) –	Cell Phone No.: ( ) –

Occupation:	Employer:	Name of Spouse: (if not Father/Legal Guardian)

Father's Last Name:	First Name:	M.I.:	Birth Date: – –	Social Security No.: / /

Street Address: ··· *Check here if same as above*	Home Phone No.: ( ) -	Work Phone No.: ( ) –	Cell Phone No.: ( ) –

Occupation:	Employer:	Name of Spouse: (if not Mother/Legal guardian)

INSURANCE INFORMATION

Primary Ins. YES NO	Policy Holder:	Relationship to Patient:

Insurance Company:	Insurance Address:	Insurance Phone No.:

Member/Subscriber ID:	Group/Plan Number:	Deductible: $	Co-Payment: $

Secondary Ins: YES NO	Policy Holder:	Relationship to Patient:

Insurance Company:	Insurance Address:	Insurance Phone No.:

Member/Subscriber ID:	Group/Plane Number:	Deductible: $	Co-Payment $

IN CASE OF EMERGENCY

Name of friend / relative (not living at same address):	Relationship to patient:	Work Phone No.: ( ) –	Cell Phone No.: ( ) –

CONSENT

The above information is true to the best of my knowledge. I give consent for treatment and authorize that my insurance benefits for covered services be paid directly to Texoma Physicians Group PLLC. I understand that I am financially responsible for any balance or service not covered by my insurance company. I authorize the Group and/or the insurance company to release any information required to process my claim. I also authorize a copy of this Consent to be used in lieu of the original. I further authorize the release of private health information to other providers involved in my child's care.

220 E. Evergreen St.
Sherman, TX 75090
Phone: 903-202-2900
Fax: 903-202-2901

Pediatric and Adolescent Medicine

____________________________________ Patient Name – PRINT

_______________ Date of Birth

___________________________ Social Security Number (Optional)

CONSENT FOR TREATMENT

The patient and/or parent/guardian/legal representative agree and consent to general medical treatment by all Texoma Physicians Group, PLLC physicians and providers and furthermore consent to the full access, review and use of the patient's medical records by all Texoma Physicians Group, PLLC. The patient and/or parent/guardian/legal representative also agrees and consents for Texoma Physicians Group, PLLC to view the patient's Rx History from an external source.

UNDERSTANDING OF FINANCIAL RESPONSIBILITY

All professional services rendered will be charged to the patient and/or guarantor. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed that the patient is responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSINGMENT OF INSURANCE BENEFITS

I hereby authorize Texoma Physicians Group, PLLC to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by any Texoma Physicians Group, PLLC physician or provider. I further understand and agree that this agreement remains in force until revoked by me in writing.

HIPAA – NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about the patient may be used and disclosed and how I can get access to this information. Per my signature below, I acknowledge that Texoma Physicians Group, PLLC Note of Privacy Practices has been provided to me if requested.

____ PRINT – Patient/Parent/Guardian/Legal Representative

____________________ Relationship to Patient

______________ Date

____ SIGNATURE – Patient/Parent/Guardian/Legal Representative