TEXAS Health and Human Services | Texas Department of State Health Services

TEXAS IMMUNIZATION REGISTRY (ImmTrac2)
ADULT CONSENT FORM

(Please print clearly)

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ ( ) Telephone _____ Email address _____ Gender: ☐ Female ☐ Male

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

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 immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac2. *For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation for that minor by completing the ImmTrac2 Minor Consent Form (# C-7) available for downloading at www.ImmTrac.com.*

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in ImmTrac2, my immunization information may by law be accessed by: a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. **I understand that I may withdraw this consent at any time.**

State law permits the inclusion of immunization records for First Responders and their immediate family members (older than 18 years of age) in the Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation as an "ImmTrac2 child" by completing the Immunization Registry (ImmTrac2) Consent Form (# C-7).

Please mark the appropriate box to indicate whether you are a <u>First Responder</u> or an <u>Immediate Family Member</u>.

☐ I am a **<u>FIRST RESPONDER</u>**. ☐ I am an **<u>IMMEDIATE FAMILY MEMBER</u>** (older than 18 years of age) of a First Responder.

By my signature below, I **<u>GRANT</u>** consent for registration. I wish to **<u>INCLUDE</u>** my information in the Texas immunization registry.

Individual (or individual's legally authorized representative): _____ 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 • ImmTrac2 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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GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

NOTIFICATION: Denton County Public Health
(Name of Health Department)

(Hereafter called the Department) encourages individuals to seek a personal physician for periodic health examinations and for treatment of health problems. The Department clinic services are targeted primarily toward prevention of health problems among those who cannot access a physician. The Department cannot assume the responsibility for payment of medical care received outside this clinic, including the delivery of babies, unless previous written authorization has been given.

DISCLAIMER ON SCREENING: The Department uses screening tests, which are a way to find people who may develop certain common medical problems. Screening tests are valuable because they can find disease early-before it becomes a big health problem. Screening tests do not cover all diseases and may miss some diseases they are supposed to find, so the test results are not final, just one part of a complete exam. Screening tests can alert you to promptly get a medical check-up and treatment from a doctor or health clinic of your choice.

GENERAL CONSENT: I give permission to the Department, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests (which may include HIV testing), give injections, medications, and other treatments, and render other health services to the patient identified on this form.

ADDITIONAL CONSENT: In addition to the above general consent, I understand that special consent forms must be read and signed for the following procedures: medications for tuberculosis and Hansen's disease, immunizations and family planning methods.

PRIVACY NOTICE: I acknowledge that I have received a copy of the Department's HIPAA Privacy Notice.

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in and that any questions I have had about the services have been answered to my satisfaction.

SIGNATURES: Fill blank lines with NA if not applicable.

Patient's Name _____ Patient's Signature_____

Person Authorized to Consent (if not patient) _____ Relationship_____

Signature _____ Date_____

I decline HIV testing at this time. If so, initial here: _____

SIGNATURES SECTION II: I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient's Name N/A

Name of Person Giving Consent N/A Signature N/A

Relationship to Patient N/A Date N/A

Address N/A

Phone Number N/A

SIGNATURES SECTION III:

Counselor Signature _____ Date_____

Leading our communities to a healthier future.

Denton County PUBLIC HEALTH

Immunization Patient Eligibility Screening: Adult

Today's Date: ____ / ____ / ____
month day year

Patient Name: _____
Last First

Patient's Date of Birth: ____ / ____ / ____ ☐ Male ☐ Female
month day year

County of Residence: _____ Veteran: ☐ Yes ☐ No

Please **check the box** for the category that applies.
Sign and date at the bottom.

The patient...

Has NO health insurance	☐
Has Adult Medicaid / Healthy Texas Women or CHIP Perinatal	☐
Has private health insurance or Medicare	☐

Check here if you are 19 years of age and have been referred to our clinic to finish a vaccine series you began when you were 18 or younger and eligible for Texas Vaccines for Children (TVFC) ☐

Referring Provider: _____

NOTE: Knowingly falsifying information on this document constitutes fraud.
By signing this form, I hereby attest that the information above is true and correct.

PATIENT SIGNATURE: _____ DATE: _____

Important Information for Former Military Service Members:
Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard may be eligible for additional benefits and services. For more information, please visit the Texas Veterans Portal at www.veterans.portal.texas.gov.

Clerical Staff Use Only: Program Eligibility	
ASN	Private Flu/Travel
Verified By (staff initials): _____	

Leading our communities to a healthier future.

Denton County PUBLIC HEALTH

Screening Checklist for Contraindications to Vaccines for Adults

Patient name _____

Date of birth _____ /_____ /_____
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you sick today? (including fever over 100.4) a. If Yes, please explain:	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex? a. If Yes, please explain:	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination? a. If Yes, please explain:	☐	☐	☐
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy? a. If Yes, please explain:	☐	☐	☐
5. Do you, or does a close family member, have cancer, leukemia, HIV/AIDS, or any other immune system problem? a. If Yes, please explain who:	☐	☐	☐
6. In the past 3 months,have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? a. If Yes, please explain:	☐	☐	☐
7. Have you had a seizure or a brain or other nervous system problem? (e.g. Guillain-Barré Syndrome) a. If Yes, please explain:	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? a. If Yes, please explain:	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations or a TB (tuberculosis) test in the past 4 weeks? a. If Yes, please explain:	☐	☐	☐

FORM COMPLETED BY _____ **DATE**_____

FORM REVIEWED BY _____ **DATE** _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

INFORMED CONSENT TO USE THE DENTON COUNTY PUBLIC HEALTH PATIENT PORTAL

The Patient Portal is a secure, internet-based messaging system that permits you to privately access your medical information and test results maintained by Denton County Public Health (DCPH). The website conforms and complies with the federal law HIPAA (Health Insurance Portability and Accountability). Data is encrypted, which safeguards against any unauthorized use. Only you will have authorized access, using your unique username and password. E-mail addresses, usernames and passwords are never shared by DCPH with other parties.

If you wish to participate in this voluntary service:

1). Read, sign and date this consent form acknowledging you understand and agree to our policy. This must be witnessed and attested to by our staff.
2). Provide us with your written, secure e-mail contact information.
3). You will then receive an e-mail with a unique identification and temporary password, through our electronic medical records vendor *eClinicalworks*.
4). Log in to the Portal website link in the e-mail with your user name and temporary password.
5). Once you are logged in you will have an opportunity to create a new password, and view your test results.

By reading, completing and signing this form I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. **I Decline Patient Portal Consent** ☐

My username and password will not be shared with others, and it is my responsibility to protect these from access by unauthorized persons.

Use of the Denton County Patient Portal System is contingent upon my maintaining satisfactory status as an active patient in DCPH clinics, and this access may be revoked or disabled without prior notification.

To continue patient Portal access, I agree to notify DCPH of any future changes in my e-mail address. I understand that my review and written consent must be updated if/when this policy is modified in the future.

Patient/Guardian Signature:_____Date: _____

Patient name: _____DOB: _____

Staff Witness:_____Date: _____

Confidential e-mail address (print clearly)_____

If the patient is a minor enter name of Parent/Guardian requesting access:

Parent/Guardian: _____Date: _____

Staff Witness:_____Date: _____