children'shealth
Medical Group

Demographics Patient Information

PATIENT REGISTRATION FORM (PLEASE FILL IN ALL FIELDS COMPLETELY)		CPS/Foster Child? Yes No
PATIENT (CHILD'S) INFORMATION		
Child's Last:	Child's First:	Child's Middle:
Child's Date of Birth:	Phone # where child lives:	☐ Male ☐ Female
Address where child lives:		Child's S.S.#
Pharmacy Name:	Pharmacy Address:	
Legal Guardian's Email Address:		
Child's Race (please check appropriate box): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Other ☐ Unknown		
Child's Ethnicity (please check appropriate box): ☐ Latino/Hispanic ☐ Other		
Child's Primary Language: ☐ English ☐ Spanish ☐ Other		

PARENT/LEGAL GUARDIAN INFORMATION # 1			
Last Name:	First Name:	Date of Birth:	Cell #
S. S. #	Relationship to Child:	Address:	Work #
☐ Lives with Child	☐ Person Responsible for Bill		

PARENT/LEGAL GUARDIAN INFORMATION # 2			
Last Name:	First Name:	Date of Birth:	Cell #
S. S. #	Relationship to Child:	Address:	Work #
☐ Lives with Child	☐ Person Responsible for Bill		

EMERGENCY CONTACT:		
Name:	Relationship to Child:	Contact #:
Name:	Relationship to Child:	Contact #:

DELEGATION OF CONSENT- Who is authorized to bring the child in for care?		
Name:	Relationship to Child:	DOB:
Name:	Relationship to Child:	DOB:
Name:	Relationship to Child:	DOB:

I certify that the information contained on this form is true and correct. Furthermore, I understand it is my responsibility and duty to inform Children's Health Pediatric Group should any information contained on this form change in the future. I further authorize the above individuals to consent to all medical care/treatment for this child by a Children's Health Pediatric Group healthcare provider. This delegation is valid until I have withdrawn this consent. I understand that the failure to be present at the time of my appointment, will result in a "no show". Any further no-shows may result in the need to transfer your care to another provider.

Signature of Parent/Legal Guardian:	Date:

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

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.**

childrenshealth
Medical Group

Demographics
Patient Information Form

REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patients Name:______________________________

Date: ______________________________

Date of birth:______________________SS#______________________Chart # ____________

I, as the patient or legal representative of the patient, request that the following protected health information

(medical records), be released for treatment purposes:

☐ All medical records of the patient indicated above

☐ Other____

I understand that the records released may include information relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS) and/or treatment for, or history of drug or alcohol abuse, mental, behavioral or psychiatric care. I understand that this authorization is voluntary and I may refuse to sign this authorization.

Release records from:
Name:
Address:
City/State/Zip:
Phone number:
Fax number:

Please send records to: Dr. ______________________________

Children's Health
Pediatric Associates of Plano
6130 W Parker Rd, Ste 410
Plano, Texas 75093
Ph: 469-303-8380 Fax: 469-303-0673
email: pap.staff@childrens.com

I understand that federal laws and regulations do not require an authorization for release of protected health information for treatment purposes. This form is to provide a formalized written manner of communication for requesting protected health information from one health care provider to another. This request will expire in 180 days unless otherwise revoked.

______________________________ Signature of Parent or Legal Guardian

______________________________ Printed Name of Parent or Legal Guardian

______________________________ Relationship to Patient

______________________________ Date