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

Texas Immunization Registry (ImmTrac2)
Minor Consent Form

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) ____/____/____ Child's Sex: ☐ Male ☐ Female Telephone ____-____-____ Email address _____

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

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

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 is a secure and confidential service that consolidates and stores your immunization records. With your consent, your immunization information will be included in ImmTrac2. Doctors, public health departments, schools, and other authorized professionals can access your immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code § 161.007 (d). *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

Consent for Registration of 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 ImmTrac2. Once in ImmTrac2, my 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 individual as a patient; a state agency having legal custody of the individual; a Texas school in which the individual is enrolled; and a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the individual. I understand that I may withdraw this consent at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas DSHS, ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2.
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 more information, see Texas Health and Safety Code § 161.00705. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Please mark the box below to indicate whether you are an immediate family member of a first responder.
☐ **I am a FIRST RESPONDER.** ☐ **I am an IMMEDIATE FAMILY MEMBER of a first responder.**

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas Immunization Registry.
Individual (or individual's legally authorized representative):

Printed Name _____ Signature _____ Date _____

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.
(Reference: Tex. Gov. Code, § 552.021, 552.023, 559.003, and 559.004)

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

Questions? Tel: 800-252-9152 • Fax: 512-776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

CONSENT FOR MEDICAL TREATMENT OF A MINOR

Name of Minor_____ Birth Date_____ Age_____

Consent by Parent/Managing Conservator/Guardian or other Adult

Name of Parent or managing conservator/guardian_____

I am the (check one): parent____ managing conservator_____ guardian_____ of the above minor.

I give permission for WAMHS to provide the minor named above confidential medical treatment. This includes permission for the minor child named above to give informed consent for the birth control method of her choice, based on consultation with the health provider. I waive my right to review and sign a consent form for the birth control method the minor chooses to use. This consent begins on the date below and remains in effect unless revoked in writing. I declare under penalty of perjury that the above information is true and correct.

_____ _____ _____

Printed name of person giving consent Signature of person giving consent Date

Complete this section only if the parent/managing conservator/guardian CANNOT BE CONTACTED.

The person having the right to consent to medical treatment for the above minor cannot be contacted and has not given notice to the contrary. As per Texas Family Code Chapter 32.001, I may consent for medical treatment of the above named minor. I am the (check one)

_____ grandparent _____adult brother/sister _____adult aunt/uncle
_____ educational institution with authorization to consent from the person having the right to consent
_____ adult with care/control/possession with written authorization to consent from the person having the right to consent
_____ adult responsible for minor under juvenile court order
_____ Texas Youth Commission staff

I give permission for WAMHS to provide the minor named above confidential medical treatment. This includes permission for the minor child named above to give informed consent for the birth control method of her choice, based on consultation with the health provider. I waive my right to review and sign a consent form for the birth control method the minor chooses to use. This consent begins on the date below and remains in effect unless revoked in writing. I declare under penalty of perjury that the above information is true and correct.

_____ _____ _____

Printed name of person giving consent Signature of person giving consent Date

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women's & men's health services
of the Coastal Bend, Inc.

3536 Holly Road
Corpus Christi, Texas 78415
361 855-9107 (ph) 361 855-6822 fax

4410 Dillon Lane, Ste 1
Corpus Christi, Texas 78415
361 857-0101 (ph) 855-0003 fax

1000 S. 14th St, Ste 1022B
Kingsville, Texas 78363
361 595-1875(ph) 595-1879 (fax)

2041 E Main St, #300
Alice, Texas 78332
361-453-4221

REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

DATE:_____ PATIENT #_____

NAME OF PATIENT:_____

DATE OF BIRTH:_____ TELEPHONE #_____

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available.

I have been given information about the test(s), treatment(s), procedure(s), contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Women's and Men's Health Services of the Coastal Bend.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in WAMHS' *Notice of Health Information Privacy Practices.* I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices.*

I hereby request that a person authorized by WAMHS provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

I hereby acknowledge receipt of Women's and Men's Health Services of the Coastal Bend's notice of health information privacy practices.

Signature of Patient_____ Date_____

I witness the fact that the patient received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

Signature of Witness_____ Date_____

Addendum to Meningococcal ACWY Vaccine: What You Need to Know Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ Meningococcal ACWY Vaccine

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)

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA Privacy Notice.

Information about person to receive vaccine (Please print)					
Name: Last	First	Middle Initial	Birthdate (mmddyyyy)	Sex (circle one)	
				M	F
Address: Street	City	County	State TX	Zip	

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

X _____ Date: _____

X _____ Date: _____
Witness

For Clinic / Office Use Only

Clinic / Office Address:	Date Vaccine Administered:
Women's & Men's Health Services of the Coastal Bend, Inc. 2041 East Main St. #300 Alice, TX 78332 Phone: (361) 453-4221 Fax: (361) 453-4229	Vaccine Manufacturer:
	Vaccine Lot Number:
	Site of Injection:
	Title of Vaccine Administrator:
	Signature of Vaccine Administrator:
	Date VIS Given:

Notice: Alterations or changes to this publication is prohibited.

Instructions: File this consent statement in the patient's chart.