***Welcome to Collin County Physicians***

Thank you for reviewing and completing the paper work. We know it is tedious but it is important. These documents contains important patient privacy related information. It also includes important information about your past medical history, medications, allergies, family history and other details that will immensely help our physicians take good care of your health

**Care coordination and Referrals:**

If your health requires, we will refer you to other physicians such as specialists or other health care providers or personnel such as as physical therapist, nutritionist, registered nurses etc. It would be our pleasure to refer you to the company or person of your choice. If you do not specify a personal preference, our physician will send your referrals to the person or company that we deem appropriate based on the location, appointment availability and other factors

If you receive care outside of our practice please let us know. This allows us to obtain health information from other providers so that we have an accurate representation of your health status each we see you. This information is collected as part of the new patient registration process; however, you may have seen another physician since your first visit. A Medical Release Form can be completed at any time. You may choose to fax the request directly to your other physician or complete the form in the office and we can fax it for you. Please include the name of the Physician you have seen and a telephone or fax number. If you have any questions about obtaining copies of medical records from outside our practice, please contact us

**Messaging:** We may not always be able to answer your phone calls. Please leave a voicemail if we do not answer. We will try to return your call within 24 hours. If you have an urgent need, please follow the instructions to speak with the physician on call. Please allow 48 hours for prescription refill requests. When leaving a message, please clearly state your name and date of birth

**Laboratory and Diagnostic Test Results:** After your physician has reviewed your test results, a nurse or medical assistant will contact you to discuss with you the physician's comments and recommendations. Results are usually available within 48 hours

**Patient Portal:** Ask about our Patient Portal. The portal allows you access to your past appointment history, notifications of upcoming appointments, and the ability to confirm or cancel a scheduled appointment. You can also update your demographic/insurance information and receive laboratory/ diagnostic test results. Results can be downloaded and/or printed directly from the portal.

**Appointments: Please use our website or** call to schedule an appointment. Please check in 10 minutes prior to your appointment so that we may update your demographic and insurance information. Late arrivals may need to be rescheduled.

Please make every effort to keep your appointments and notify the office as early as possible to cancel or reschedule. Last minute cancellations or failing to show without advanced notice may result in a No-Show charge.

**Patient Satisfaction Survey:** We are committed to quality. You may receive a survey regarding your visit. We encourage you to complete the survey to help us improve our quality of service to you.

**Notice of Privacy Practices**

This office may use and disclose medical and financial information related to your care that may be necessary now or **in** the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies. **HM**O's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third-party payers, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

We may use or disclose your protected health information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we *receive* financial remuneration from a third party in connection with such communications. You have the right to opt out of receiving any such compensated communications and should inform us if you do not wish to receive them. Additionally, if we send such communications, the communications themselves note that we have received compensation for the communication and will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Other than expressly provided herein, any other disclosures of your protected health information will require your specific authorization. Most disclosures of protected health information, for which we would *receive* compensation, would require your authorization. Additionally, we would need your specific authorization for most disclosures of your protected health information to the extent it constitutes "psychotherapy notes".

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. As stated above, in most instances we do not have to abide by your request for restrictions on disclosures that are otherwise allowed. However, in certain instances, if you make a request for restrictions on disclosures, we will be obligated to abide by them. Specifically, if you pay for an item or service in full, out of pocket, and request that we not disclose the information relating to that service to a health plan, we will be obligated to abide by that restriction. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

To the extent that this office maintains your Protected Health Information (PHI) in an electronic health record, we agree to account for all disclosures of such PHI upon your request for a period of at least three (3) years prior to such request, as required by HIPM.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your protected health information has been improperly disclosed or otherwise subject to a "breach" as defined in HIPAA.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Hunan Services. You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices is effective as of September 23, 2013.

**PATIENT INFORMATION**

|  |  |
| --- | --- |
| Last Name:  First Name: MI: Previous Name:  (Maiden name, former married name, etc.)  Home  Address:  (No PO boxes)  City:  State: Zip Code: Primary( ) □Cell Phone □Home Phone Secondary( ) □Cell Phone □Home Phone | Date of Birth: O Male **O** Female Marital Status: **0** Single **O** Married **O** Divorced **O** Widowed  **0** Legally Separated **O** Partner  Social Security Number: Employer Name:  **0** Full Time □Part Time Whom may we thank for referring you to our practice?  Race: **0** African American □Asian **O** Hispanic **O** Native American  **0** White **O** Pacific Islander **O** Other **O** Declined Ethnicity:**0** Hispanic/Latino **O** Not Hispanic/Latino **O** Declined |
| Please sign up for our **patient portal** today. Our portal gives you access to your health-care data (medication list, laboratory results and medical summary) and most importantly you can  communicate with us through the secure portal system. You can | Does someone care for you at home? If so, who? Is this person your guardian/legal proxy? **0**Yes □No  What is your primary language? □English □Spanish **O** Other Do you require the assistance of a translator? □Yes □No |
| ask questions or refill your medications through the portal. Please | **Pharmacy Information:** |
| be advised that it may take up to 3 working days to answer your | Name: |
| request. | Location (City & Intersection): |
| **Patient's Email:** | Phone: Fax: |

**Responsible Party (if different from patient information above)**

Name: Date of Birth:

Relationship: □Self □Spouse □Parent □Other Social Security Number: \_ Street Address:

City /State/ Zip Code: Home Phone:------·----------

**Minor Consent (Required if the patient is under the age of 18):**

I ( )am the parent and/or legal guardian of anIdhereby give my consent to Doctors of Internal Medicine/ Doctors of Primary Care at McKinney to give medical treatment as deemed necessary by the physician and/or his/her Physician's Assistant or Nurse Practitioner.

Signature of Parent/Legal Guardian Date

**Financial Policy**

Payment is required for all services at the time they are rendered. We do not accept any health insurance except Medicare. All fees and other money paid to our office are nonrefundable. Applicable co-payments, estimated deductibles, coinsurance and non-covered services will be collected.

Our prices are listed on our website. Please note that the pricing list is not all inclusive and you may have to pay a different amount for services that are not listed on the website

We will provide you a detailed invoice also known as a superbill. You may submit the invoice to your health insurance company if you have health insurance. Your health insurance company may then reimburse you all or some of the money you paid to us. However, we do not guarantee that your health insurance company will make any such payments to you. We will not be responsible for submitting any bills, invoices or other paperwork to your health insurance company. Please discuss any possible reimbursement directly with your health insurance company

In the event an overpayment has been made and to ensure the most accurate refund amount, please be advised that our office cannot issue any refunds until all line items have been finalized by your insurance.

We accept payment in the form of cash, check, and all major credit cards. If a check is returned to our office, there will be a $35.00 return check fee added to your account. Please note that all future appointments will need to be paid with cash, credit card or money order only. For appointments which are missed or cancelled with less than 24-hour notification, there may be a $25.00 missed appointment fee added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

I have read and understand the financial policy statement. I agree to make, in-full, prompt payment to Collin County Physicians before my appointment or when billed for

In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Name:

Signature Date

Consent for Treatment

I hereby consent to evaluation, diagnostic procedures, testing and treatment as directed by my physician or his/her designee. I understand that this consent to treat will be valid indefinitely and for each visit I make to Collin County Physicians until revoked by me in writing.

By signing below, I understand and agree to all stated and filled in above.

Signature Date

Patient Name (Please print clearly) Date of Birth

#### Authorization to Leave aVoicemail

At Collin County Physicians, we do our best to reach you via phone regarding any issues that may arise. Unfortunately, there may be times that you are not reachable and we may need to leave a detailed message to communicate with you.

Please provide two (2) phone numbers that we can leave detailed messages regarding billing and scheduling issues or any medical issues including test results.

Primary Phone Number \_ Secondary Phone Number \_

□--Please check and initial here, if you **DO NOT** want to authorize such detailed communication via voicemail.

#### Personal Representative Authorization for Medical Release Form

Under HIPAA requirements, we are not allowed to discuss any of your health information with anyone else without your consent. I authorize this facility to speak to the following family members or my personal representative regarding:

□ All medical information, including but not limited to: appointments, billing, test results, diagnosis, and

procedures.

The above medical information shall only be released to the following person(s):

1. Relationship: Phone number: \_
2. Relationship: Phone number: \_
3. Relationship: Phone number: \_

□ Do not disclose any information on file other than to patient on record.

#### In case of an emergency please contact:

Relationship: Phone number:

**Privacy Practices (HIPAA)**

I have been given the opportunity to review, understand and consent to this practice's Notice of Privacy Practices as written. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

Signature Date

Patient Name (Please print clearly) Date of Birth

### Health History Questionnaire

All questions are confidential and will become part of your medical record.

##### Name Date / /

Date of Birth *I I* □**M** □ F Marital Status --------

Whom may we thank for referring you to our practice? What problem brought you to the doctor?

**MEDICAL CONDITION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Date Diagnosed** | **Type of Treatment Received (i.e. medication, hospitalization, chemotherapy, radiation, etc.)** | **Date Resolved** |
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**PRIOR SURGERIES**

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| --- | --- |
| **Type of Surgery** | **Date** |
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**DEPRESSION SCREENING**

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| --- | --- | --- | --- |
| In the last 2 weeks, have you found you have had less pleasure in doing activities that you normally do? | Yes | / | No |
| Any feelings of being down, depressed, or hopeless? | Yes | *I* | No |

## Name Date of Birth / /

**MEDICATIONS {Please include over-the-counter medications and herbal supplements)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dose**  **(mg., units, etc.)** | **Frequency** | **Date Started** | **Last Taken** |
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**ALLERGIES**

|  |  |
| --- | --- |
| **Drugs** / **Foods** | **Reactions** |
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**SOCIAL HISTORY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| What is your Occupation? | | | | | Education Level: (circle one)  HS /Tech/ Some College/ Bachelors/ Masters/ Doctorate | |
| Do you currently smoke? | Yes | *I* | No |  | Age started: Average # of packs per day: Total years you smoked:  Are you interested in quitting? Yes *I* No  Age quit: | |
| Are you a former smoker? | Yes | *I* | No |  |
| Do you drink alcohol? Yes *I* No  How often do you drink? daily / weekly / monthly / yearly | | | | | Whenever you do drink, how many drinks do you consume?  Do you ever consume 6 or more drinks in 1 day? Yes / No | |
| Do you drink caffeinated beverages? | Yes | *I* | No |  | Average number per day: | coffee / tea / soda |
| Do you exercise regularly? (type of exercise | Yes | *I* | No | ) | Average# of times per week: Average # minutes per session: | 1-2 3-5 5-7  < 30 30-60 60-90 |
| Have you ever used drugs? | | | | | Type: | current use *I* past use |
| Are you engaged in activity that puts you at risk for HIV? | | | | | | |
| Do you wear seat belts? | | | | | Do you see the ophthalmologist regularly? Date of your last eye exam: | |

## Name

## **HEALTH MAINTENANCE**

## Date of Birth / /

|  |  |  |  |
| --- | --- | --- | --- |
| Date of last physical exam: | | | |
| Date of last cholesterol testing: | Total Cholesterol: | LDL: HDL: Triglycerides: | |
| Date of last colonoscopy: | Results: | Anv polyps? | |
| Date of last upper GI or endoscopy: | Results: |  | |
| Date of last PSA: | Normal / Abnormal | If abnormal, any other testing or treatment? | |
| Date of last EKG: | Results: |  | |
| Date oflast stress test of heart: | Results: | Type of stress tests (treadmill/ chemical/ nuclear/ echo) | |
| Immunizations and Dates | □ Tetanus (Td/ Tdap) please circle one | | □ Hepatitis A |
| □ Covid-19 | □ Influenza | | □ Hepatitis B |
| □HPV | □ Pneumonia | | □ Shingles |

**WOMENS HEALTH**

|  |  |
| --- | --- |
| Age at onset of menstruation: | Age at onset of menopause (if applicable): |
| Periods every days. | Date of last menstrual period. |
| Heavy periods, irregularity, spotting, pain, or discharge? | |
| Number of pregnancies: | Number oflive births: Number of miscarriages / abortions: |
| Current method of contraception: | |
| Date of last Mammogram: | Normal / Abnormal If abnormal, any other testing or treatment? |
| Date of last Pap smear: | Normal/ Abnormal If abnormal, any other testing or treatment? |
| Date of last Bone Density test: | Normal / Abnormal If abnormal, any other testing or treatment? |

**FAMILY HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Relative** | | **Significant Medical Problem** | | **Age** | **and Cause of Death** |
| Father | |  | |  | |
| Mother | |  | |  | |
| Brother | # -- |  | |  | |
| Sisters | # -- |  | |  | |
| Grandfather | | Paternal: | Maternal: | Pat: | Mat: |
| Grandmother | | Paternal: | Maternal: | Pat: | Mat: |
| Uncles | | Paternal: | Maternal: | Pat: | Mat: |
| Aunts | | Paternal: | Maternal: | Pat: | Mat: |

### Name

Date of Birth /

/

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|  |  |
| --- | --- |
| **Past Present Condition** | **Past Present Condition** |
| **General Health**  □ □ Fatigue  □ □ Fever  □ □ Unexpected weight loss or gain  **Eyes**  □ □ Blurred vision  □ □ Double vision  □ □ Cataracts  □ □ Glaucoma  **Head /Neck**  □ □ Hay fever (pollen allergy)  □ □ Hearing loss  □ □ Neck pain  □ □ Sinusitis/ sinus problems  **Cardiovascular**  □ □ Circulatory problems  □ □ Coronary heart disease  □ □ Congestive heart failure  □ □ Arrhythmias (irregular heartbeat)  □ □ Heart murmur / valve condition  □ □ High blood pressure  □ □ High cholesterol  **Respiratory**  □ □ Asthma  □ □ Emphysema/COPD  □ □ Cough  □ □ Pneumonia  □ □ Shortness of breath  □ □ TB  **Breast**  □ □ Abnormal mammogram  □ □ Breast lumps  □ □ Breast biopsies  **Gastro-Intestinal**  □ □ Colon polyps  □ □ Constipation  □ □ Diarrhea  □ □ Diverticulosis/diverticulitis  □ □ Hemorrhoids  □ □ Hernia  □ □ Hepatitis  □ □ Jaundice  □ □ Irritable bowel syndrome  □ □ Liver disease  □ □ Ulcers | **Genital and Reproductive**  □ □ Abnormal pap smear  □ □ Genital warts / HPV  □ □ Infertility  □ □ STD  (herpes, gonorrhea, chlamydia, etc.)  **Urinary**  □ □ Incontinence (loss of urine)  □ □ Kidney disease  □ □ Prostate enlargement (BPH)  □ □ Slow urine stream  □ □ Frequent urination  **Musculoskeletal**  □ □ Arthritis  □ □ Gout  □ □ Joint pains  □ □ Muscle aches  **Skin and Lymph Nodes**  □ □ Eczema  □ □ Lymph node swelling  □ □ Other skin disorder  **Neuro**  □ □ Headaches  □ □ Seizures / epilepsy  □ □ Stroke  **Psychiatric**  □ □ ADD/ADHD  □ □ Alcohol/ Drug problems  □ □ Anxiety / Panic attacks  □ □ Depression  □ □ Eating disorder  □ □ Insomnia  **Endocrine**  □ □ Diabetes  □ □ Thyroid problems  **Heme-One and Immunology**  □ □ AIDS /HIV  □ □ Anemia  □ □ Blood clots  □ □ Cancer  □ □ Easy bleeding  □ □ Easy bruising  □ □ Sickle cell anemia  □ □ Transfusion |

**OTHER HEALTHCARE PROVIDERS THAT YOU SEE**

|  |  |
| --- | --- |
| **Name** / **Specialtv** | **Name/ Specialty** |
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TEXAS

O

Health and Human

Services

(Please print clearly)

**Texas Department of State**

**Health Services**

**TEXAS IMMUNIZATION REGISTRY (ImmTrac2)**

# ADULT CONSENT FORM

First Name

*\_.! \_.! \_*

Date of Birth (mm/dd/yyyy)

Middle Name

D Female Gender: **D**

Male

Last Name

Telephone Email address

Address Apartment # / Building #

City State Zip Code County

Mother's First Name Mother's Maiden Name

|  |  |  |
| --- | --- | --- |
| **Race (select all that apply)** |  | **Ethnicity (select only one)** |
| D American Indian or Alaska Native D Asian | **D** Black or African-American | D Hispanic or Latino |
| D Native Hawaiian or Other Pacific Islander D White | D Other Race | D Not Hispanic or Latino |
| **D** Recipient Refused |  | D Recipient Refused |

|  |  |
| --- | --- |
| 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 famify 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.*](http://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 First Responder or an Immediate Family Member.**  □ I ill1 a FIRST RESPQNDER, □ I am an IMMEQIAIE EAMILY MEMBER (older than 18 ars of age) ofa First B.es12onder, | |
| 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 | |
| Date | Signature |



**rivacy Notification:** With few exceptions, you have the right to request and be informed about information that the State of Texas collects about ou. 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 hat is determined to be incorrect. See *http· I lwwm dshs texas,g11v* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

**Questions?** (800) 252-9152

**Texas Department of State Health Services**

(512) 776-7284 Fax: (866) 624-0180 www;ImmTrac com

• **ImmTrac Group** • **MC 1946** • **P. 0. 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.**

Stock No. Fl 1-13366 Revised 02/2021

* TEXAS I

H•alth and Human

# REGISTRO DE INMUNIZACI6N DE TEXAS (lmmTrac2) ;.

**Sorvlces Health Services**

**Texas Department** of **State**

(Llene a mano claramente)

# CONSENTIMIENTO PARA ADULTOS

Primer nombre

*\_,! \_.! \_*

Fecha de nacimiento (mm/dd/aaaa)

Segundo nombre

**D** Femenino

Sexo: **0** Masculine Telefono

Apellido

Correo electr6nico

Direcci6n Num. de apartamento o edificio

Ciudad Estado C6digo postal Condado

Nombre de la madre Apellido de soltera

**Grupo etnico (seleccione solo una):**

**D** Hispanic o latino

**D** No hispano o latino

**0** Se neg6 a contestar

**D** Negro o afroamericano

**O** Otto

**0** Nativo de Hawai o de otra isla de! Pacifico **D** Blanco

**0** Se neg6 a contestar

**Raza (seleccione todos los que correspondan):**

**0** Indio americano o nativo de Alaska **D** Asiatico

|  |
| --- |
| El Registro de Inmunizaci6n de Texas es un servicio gratuito de! Departamento Estatal de Servicios de Salud (DSHS) de Texas. Se trata de un servicio seguro y confidencial que consolida los registros de vacunaci6n con fines de salud publica (por ej., para darle a cada medico que atienda a un paciente un lugar centralizado donde pueda ver los registros de vacunaci6n de sus pacientes). Al darnos usted su consentimiento, los datos sobre sus vacunas se incluiran en el ImmTrac2. *En el caso de un menor de 18 anos de edad, uno de los padres, el tutor legal o el titular de la custodia puede dar el consentimiento para que ese menor participe, llenando el consentimiento de/ ImmTrac2 para menores de edad (# C-7), que puede descargar en:* [*www.ImmTrac.com.*](http://www.ImmTrac.com/) |
| **Consentimiento para el registro y para divulgar los registros de inmunizaci6n a las personas o entidades autorizadas** Entiendo que, al dar aqui mi consentimiento, autorizo la divulgaci6n de mis datos de vacunaci6n al DSHS, y entiendo ademas que el DSHS incluira esta informaci6n en el Registro de Inmunizaci6n de Texas. Una vez que la informaci6n sobre mis vacunas este en el ImmTrac2, las siguientes entidades tendran, por ley, acceso a ella: un medico u otro proveedor de salud de Texas legalmente autorizado para administrar vacunas, como parte de! tratamiento que yo reciba como paciente; cualquier escuela de Texas en la que yo este inscrito; un distrito de salud publica o departamento  de salud local de Texas, por razones de salud publica, dentro de sus zonas de jurisdicci6n; cualquier entidad estatal que tenga custodia sobre *mi;* cualquier pagador autorizado por el Departamento de Seguros de Texas para operar en Texas lo relacionado con mi cobertura con una p61iza de dicho pagador. **Entiendo que puedo retirar mi consentimiento en cualquier momento.** |
| La ley estatal permite la inclusion en el ImmTrac2 de los registros de vacunaci6n de los socorristas y sus familiares directos (mayores de 18 af10s). Se define como "socorrista" al empleado de la seguridad publica o voluntario entre cuyas funciones esta responder rapidamente a una emergencia medica. Se define como "familiar directo" a los padres, c6nyuges, hijos o hermanos que viven en el mismo hogar que el de! socorrista. En el caso de unfamiliar menor de 18 aiios, uno de los padres, el tutor legal o el titular de la custodia puede dar el consentimiento para que el menor participe en calidad de "menor en el ImmTrac2", llenando el formulario de consentimiento (# C-7) del Registro de Inmunizaci6n (ImmTrac2).  **Marque la casilla correspondiente para indicar si es usted es un socorrista** o **un familiar directo de un socorrista.**  □ SQ}'. yn SQCQRB.ISIA, D *Soi* YD EAMILIAR rHRECIQ (mil}'.or d H! afiQS) d yn SQ Qrrista, |
| Con mi firma a continuaci6n, DOY mi consentimiento para el registro. Deseo INCLUIR mis datos en el Registro de Inmunizaci6n de Texas.  **La persona (o su representante legalmente autorizado):**  Nombre escrito a mano |
| Fecha Firma |

**Aviso de confidencialidad:** Con ciertas excepciones, usted tiene derecho a pedir ya ser informado sobre los datos que el estado de Texas recaba sabre usted. Usted tiene derecho a recibir y revisar la informaci6n si asi lo pide. Tambien tiene derecho a pedir que la dependencia estatal corrija cualquier informaci6n que se determine que es incorrecta. Consulte el sitio *http· I I www.dshs texasgov* para mas informaci6n sobre el aviso de confidencialidad. (Fuente: Codigo gubernamental, secciones 552.021, 552.023, 559.003 y 559.004)

**,:Tiene alguna pregunta?** (800) 252-9152

**Texas Department of State Health Services**

(512) 776-7284 Fax: (866) 624-0180 www:ImmTrac com

• **lmmTrac Group** • **MC 1946** • **P. 0. 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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Authorization for Use and Disclosure of Protected Health Record Information

#### From Physician Name Fax \_ The information that is to be released from my medical records is for the following purpose:

Is authorized to release the following:

□ Discharge Summary □ History and Physical □ Operative Reports □ Pathology Reports

□ Laboratory Reports □ Consultation Reports □ EKG/ECHO □ Emergency Room Records

□ Shot Records □ Progress Notes □ X-Ray Reports/Films □ Occupational Health

□ Senior Health Records □ Basics/ Abstracts □ Psychiatric Records □ Continued Medical Care

□ Complete Records □ Itemized Bill □ Billing / Claims □ Other:

To Phone Fax

#### Releasing information about drug abuse, alcohol abuse, psychiatric care, and SI'Ds

I understand if my medical or billing records contain information that reference my drug abuse, alcohol abuse, psychiatric care, sexually transmitted disease history, Hepatitis B or C testing, and/or other sensitive information, I still agree to its release.

**Please check one: Yes No** Initials

I understand if my medial or billing record contains information that refers to HIV/AIDS (Human

Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I still agree to its release. Please check one:\_ Yes\_ No \_Jnitials Time limit and right to revoke authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Doctors of Internal Medicine.

Re-disclosure

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act (HI PAA-Act of 1996). DIM its employees are hereby released from any form of legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Management of medical records

I understand that once DIM have received and reviewed these medical records, the necessary records will be scanned into the patient's chart and the remaining medical records will be properly disposed of per HIPAA standards.

Signature of patient or personal representative

I authorize Collin County Physicians to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for copies.

Signature of patient or legal representative Date

Printed Name (or representative) DOB