Texas Department of State Health Services

ImmTrac2 Immunization Registry
(RECIÉN NACIDO) FORMULARIODE REGISTRO

(Favor de escribir claramente con letra de molde)

Apellido del Niño(a)

Nombre del Niño(a) **Segundo Nombre del Niño(a)**

__/__/____ *Solo recién nacidos.

Fecha de Nacimiento del Niño(a)

Género: ☐ **Masculino** ☐ **Femenino**

Nombre de la Madre **Apellido de Soltera de la Madre**

Dirección de la Madre, Calle **Apartamento #** **Teléfono**

Ciudad **Estado** **Código Postal** **Condado**

El registro de inmunización (ImmTrac) de Texas, es un servicio gratis que proporciona el Departamento Estatal de Servicios de Salud (DSHS). El registro de inmunización es un servicio seguro y confidencial que consolida y guarda el récord de inmunizaciones de su niño(a) (menores de 18 años de edad). Con su consentimiento, la información de la inmunización de su niño(a) será incluida en ImmTrac2. Los doctores, departamentos de salud pública, escuelas y otros profesionales autorizados pueden tener acceso al historial de inmunización de su niño(a) para asegurar que las vacunas importantes no le falten.

El Departamento Estatal de Servicios de Salud de Texas (DSHS) le anima a que participe voluntariamente en el registro de inmunización de Texas.

Consentimiento Para Registrar al Menor y Dar a Conocer los Documentos de Inmunización a las Entidades Autorizadas

Entiendo que, con mi consentimiento a continuación, autorizo que se dé a conocer la información de inmunización del menor al DSHS, y además entiendo que el DSHS incluirá esta información en el registro central de inmunización del estado ("ImmTrac2"). Una vez que la información del menor esté en ImmTrac2, por ley la puede acceder:

- el distrito de salud pública o el departamento de salud local, para propósitos de salud pública dentro de sus áreas de jurisdicción;
- el médico, o algún otro proveedor de atención de salud legalmente autorizado para administrar vacunas, en el tratamiento del menor como paciente;
- la agencia estatal que tenga la custodia legal del menor;
- la escuela o la guardería de Texas en que el menor esté inscrito;
- el pagador, actualmente autorizado por el Departamento del Seguro de Texas para operar en Texas, con respecto a la cobertura del menor.

Entiendo que puedo retirar este consentimiento para incluir información sobre el menor en el Registro de ImmTrac2 y mi consentimiento para dar a conocer la información del registro en cualquier momento mediante comunicación escrita a Texas Department of State Health Services, ImmTrac Group – MC 1946, P. O. Box 149347, Austin, Texas 78714 - 9347.

Favor de marcar la caja ☑ indicando la selección de su preferencia.

☐ YO **AUTORIZO** el consentimiento para registrarlo. Deseo **INCLUIR** la información de mi niño(a) en el registro de inmunización de Texas.

☐ YO **NIEGO** el consentimiento para registrarlo. Deseo **EXCLUIR** la información de mi niño(a) del registro de inmunización de Texas.

Alguno de los padres, tutor legal o administrador de bienes: ____________________
Escriba con letra de molde

Fecha: __________ Firma: ____________________

Notificación Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a *http://www.dshs.texas.gov* para más información sobre la Notificación sobre privacidad. (Referencia: Government Code, sección 552.021, 552.023, 559.003 y 559.004)

Al rellenarlo, mándelo por fax o correo postal al Grupo ImmTrac2 del DSHS o a un proveedor de salud inscrito.

¿Tiene preguntas? (800) 348-9158 • (512) 776-7284 • www.ImmTrac.com • ImmTrac2 NB-2

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

BIRTH REGISTRARS

Please enter newborn client information in the Texas Electronic Registrar and **affirm** that consent has been granted.
DO NOT fax to DSHS. Retain this form in the client's birth record.

Stock No. F11-11936 Revised 03/2017

Texas Department of State Health Services

Texas Vaccines for Children (TVFC) Program

Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children (TVFC) Program must be kept in the health care provider's office for a minimum of five (5) years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

1. Child's Name: ______________________________
   Last Name First Name MI
2. Child's Date of Birth: ____/____/______
   MM DD YYYY
3. Parent, Guardian, or Individual of Record: ______________________________
   Last Name First Name MI
4. Primary Provider's Name: ______________________________
   Last Name First Name MI
5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the TVFC Program, at each immunization encounter or visit, enter the date and mark the appropriate eligibility category. If Column A - F is marked, the child is eligible for the TVFC Program. If column G is marked the child is not eligible for federal VFC vaccine.

Date	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	* Underinsured served by FQHC, RHC, or deputized provider	** Other underinsured	*** Enrolled in CHIP	Has health insurance that covers vaccines

** Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC), a Rural Health Clinic (RHC), or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC or an RHC and the state, local, or territorial immunization program in order to vaccinate underinsured children.*

*** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the TVFC Program because the provider or facility is not an FQHC or an RHC, or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-TVFC-eligible children.*

**** Children enrolled in the State of Texas Children's Health Insurance Program (CHIP). An agreement between the DSHS Immunization Unit and CHIP stipulates that vaccines for eligible CHIP enrollees are purchased through the federal contract.*

Texas Vaccines for Children (TVFC) Program

Patient Eligibility Screening Record

(Continued)

Date	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	* Underinsured served by FQHC, RHC, or deputized provider	** Other underinsured	*** Enrolled in CHIP	Has health insurance that covers vaccines

Medicaid:

Medicaid Number:________________________

Date of Eligibility:________________________

CHIP:

CHIP Number:________________________

Group Number:________________________

Date of Eligibility:________________________

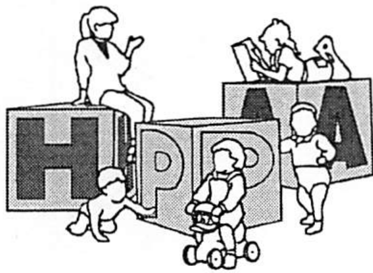
Private Insurance:

Name of Insurer:________________________

Insurer Contact Number:________________________

Insurance Name:________________________

Policy or Subscriber Number:________________________



Harlingen Pediatrics Associates

Medical Records Release Form
(Please circle **Release** or **Request**)

Patient Name____**DOB**__________________

Address____**Phone#**________________
Street **City, State, Zip**

By Signing this form, I hereby authorize the **RELEASE** or **REQUEST** of medical records **to and or from** the person(s) or entity below.

Name____

Address____

City____________________________________**State**____________________**Zip**____________

Phone__________________________________**Fax**______________________________________

Please **RELEASE** or **REQUEST** the following:
_____Complete Medical Chart_____Immunization Records_____Other_____

Your Initials are required to release the following information:
___Mental Health Records (excluding psychotherapy notes)
___Drug, Alcohol, or Substance Abuse Records
___Genetic Information (including Genetic Test Results)
___HIV/AIDS Test Results/Treatment
HIV/AIDS: I consent to the release of any positive or negative test for AIDS or HIV Infection, antibodies to AIDS or infection with any causative agent of AIDS with the rest of my medical records.

I, the undersigned, have read the above and authorized the staff of **Harlingen Pediatrics Associates** to disclose or request such information as herein contained. I understand that his consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other that the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information." Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization is for **(1)** conducting research related treatment, **(2)** obtaining information in connection with the eligibility for enrollment in a health plan, **(3)** determining an entity's obligation to pay a claim, or **(4)** creating health information to provide a third party.
This authorization expires one year from the date signed below.
I, understand that you will provide this information with **15 days** from the receipt and that **a fee for preparing and furnishing this information may be charged according to the rulings set forth by the Texas Board if medical Examiners.**

ONCE YOU LEAVE OUR PRACTICE, YOU WILL NO LONGER BE ABLE TO RECEIVE MEDICAL CARE AT HPA.

____
Signature of parent/guardian(patient if over 18 years of age.) Date

____
Signature of witness

Maribelle Garza, M.D. • Francisco R. Papilla, M.D. • Erwin D. Sanchez, M.D. • Natalie Ayala, M.D.
Sally S. Villarreal, M.D • Stephanie R. Hinojosa, M.D. • Leticia Garcia, FNP-BC • Alicia Gonzalez, FNP-C

321 S. 21st Street / Harlingen, TX 78550 / 956-425-8761 / FAX 956-425-9207