The Children's Clinic

Patient Information Form

Patient Demographics	
Patient Name:	
Date of Birth:	Social Security #:
Parent Demographics	
Mother's Name:	Maiden Name:
Address:	City/Zip:
Home Phone #:	Alternate Phone #:
Date of Birth:	Social Security #:
Employer:	Work Phone #:
Father's Name:	
Address:	City/Zip:
Home Phone #:	Alternate Phone #:
Date of Birth:	Social Security #:
Employer:	Work Phone #:
Insurance Information	
Primary Insurance Company:	Policy Number:
Subscriber Name and Date of Birth:	Group #:
Employer Name:	
Secondary Insurance Company (if applicable):	Policy Number:
Subscriber Name and Date of Birth:	Group #:
Employer Name:	
In case of emergency contact: (Please include name, phone number and address)	

The Children's Clinic
Health Information Exchange
Opt-In/Out Form

Children's Clinic will be offering a new service called the **Health Information Exchange (HIE) Network**. This program will allow your doctors to get up to date health facts about you and your family. Your doctors will then have the medical facts they need to help you. These facts include: allergies, medications you are taking, test results, and any health problems you are dealing with. This helps each doctor give you the best possible care based on your medical history. These facts will only be shared with those doctors that you are seeing.

Even though the HIE may help you, you can choose if you want to use this service. If you decide not to use the HIE, or to *Opt-Out*, you will still get good health care from your doctors. However, they won't be able to see your medical facts through the HIE. Your doctors will have to get your medical facts in other ways, such as asking for it from other doctors.

Participating in the HIE is your choice. Here are some ways it can help you:

> **Emergency Care:** In an emergency the Medical Staff would be able to see all of your medical facts. This would help them diagnose the problem more quickly so they can begin to help you.
>
> **Better Care:** When your doctors have all of your medical facts they will have a better idea about what you need. This will also help your safety. There is less chance you will be given medications that shouldn't be taken together. You are also less likely to have dangerous reactions to things you are allergic to. The HIE will allow doctors to see what tests have been done. They can then decide what to do next.
>
> **Patient Control:** You can take a more active role in your health and the health of your family. You can receive a print-out of all your medical facts. You can share it with other doctor.

Permission to Opt-Out (not use) HIE:

The Children's Clinic will use the HIE until you or your family member fills out an *Opt-Out Request Form*. Once we receive this form, your medical facts will *not* be shared for any doctor visits in the future. This won't affect facts that have already been shared in the past. If you wish to use the HIE in the future, you must fill out another form to get it started.

HEALTH INFORMATION EXCHANGE (HIE)
OPT-IN/OUT FORM

☐ **To Opt-In (use) the HIE: Please read, fill in information & sign below:**

"I understand that by completing this form, I am *Opting In* to the HIE. By *Opting In,* my medical facts will be given to doctors through the HIE from now on. I understand that my doctor can get my medical facts in other ways. This will be in ways that the law permits. I understand that I can change my mind later and discontinue using the HIE. I can do this by filling out this letter and giving it to the Children's Clinic staff that is checking me in."

☐ **To Opt-Out (not use) the HIE: Please read, fill in information & sign below:**

"I understand that by completing this form, I am *Opting Out* of the HIE. By *Opting Out,* my medical facts will *not* be given to doctors through the HIE from now on. I understand that my doctor can get my medical facts in other ways. This will be in ways that the law permits. I understand that I can change my mind later and begin using the HIE again. I can do this by filling out this letter and giving it to the Children's Clinic staff that is checking me in."

Child's First and Last Name (Print):_____

Date of Birth: _____ Member ID: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone Number: _____ E-mail Address: _____

_____ _____

Signature of Member or Authorized Representative Date

_____

Witness

COASTAL CHILDREN'S CLINIC
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Coastal Children's Clinic. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____
Printed Patient Name Date of Birth Printed Parent/Guardian Name

_____ _____
Relationship to Patient Signature

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR CHILDS HEALTH INFORMATION. (This includes step parents, grandparents, and any caretakers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PLEASE LIST ANY OTHER PARTIES WHO **CANNOT** HAVE ACCESS TO YOUR CHILDS HEALTH INFORMATION.

Name: _____ Name: _____

I AUTHORIZE **INFORMATION ABOUT MY CHILD'S HEALTH** BE CONVEYED VIA:
☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Work Phone Confirmation ☐ Any of the above

I ☐ AUTHORIZE ☐ DO NOT AUTHORIZE **INFORMATION ABOUT MY CHILD'S HEALTH (INCLUDING IMMUNIZATION RECORDS)** BE FAXED/MAILED TO MY CHILD'S SCHOOL.

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFORMATION** ON BEHALF OF COASTAL CHILDREN'S CLINIC VIA:
☐ Phone Message ☐ Text Message ☐ E-mail ☐ Any of the Above ☐ None of the Above (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Authorization to Release Medical Information

_____ _____/_____/_____
Patient Name (Print) Patient Date of Birth

I authorize _____ to use or release/disclose my health information as described below. (In blank space please print previous doctor's name and phone number.)

Please identify the information to be released:

- ☐ Please release my entire record

  -OR-

- ☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated)
  - o Problem List
  - o Medication List
  - o List of allergies
  - o Immunization records
  - o Most recent history
  - o Most recent discharge summary
  - o Lab results (please describe the date or types of lab tests you would like disclosed):_____
  - o X-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed):_____
  - o Consultation report (please supply doctors' names):_____
  - o Other (please describe):_____

The identified information will be used for the following purpose:

- ☐ My personal records
- ☐ Sharing with other health care providers as needed
- ☐ Other (please describe):_____

Please initial each item below to indicate your understanding.

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following organization: (If over 25 pages please mail records.)

The Children's Clinic
3435 S Alameda
Corpus Christi, TX 78411
Attn: Registration Dept
Phone: 361-855-7346 x 116 Fax 361-855-8596

This authorization will expire on (insert date or event):_____. If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ _____/_____/_____
Patient Signature (or signature of person completing form if not Patient*) Date
*Relationship to patient: _____Parent _____ Legal Guardian _____ other: _____

_____ _____/_____/_____
Witness Signature Date

The Coastal Children's Clinic
3435. S. Alameda
Corpus Christi, Tx 78411

I Authorize _____, relationship to patient _____

_____, relationship to patient _____

_____, relationship to patient _____

_____, relationship to patient _____

To seek medical attention for my child(ren)'s for sick visits, physicals, immunizations and also releasing any information (PHI) regarding the child(ren)'s medical condition

_____ _____
Name of Patient Date of Birth

_____ _____
Name of Patient Date of Birth

_____ _____
Name of Patient Date of Birth

_____ _____
Name of Patient Date of birth

_____ _____
Name of Patient Date of Birth

_____
Please print Parent or Legal Guardian Name

_____ _____
Signature of Parent or Legal Guardian Date

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
MINOR CONSENT FORM

ImmTrac
Texas Immunization Registry

(Please print clearly)

For Clinic/Office Use

Child's Last Name

Child's First Name **Child's Middle Name**

Child's Date of Birth ***Children under 18 years only.**

Child's Gender: ☐ **Male** ☐ **Female**

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac, 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 (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. 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 ("ImmTrac"). Once in ImmTrac, 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 ImmTrac 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.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.

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

Stock No. C-7
Revised 05/18/2012

TEXAS Department of State Health Services

PROVIDERS REGISTERED WITH ImmTrac** – Please enter client information in ImmTrac and **affirm** that consent has been granted. **DO NOT fax to ImmTrac**. **Retain this form in your client's record.