Park Cities Pediatrics

CONSENT TO TREAT

I give consent for diagnosis and treatment to Park Cities Pediatrics to provide medical care reasonable by today's standards to my minor child. This includes, but is not limited to: physical examination, evaluation of illness and injuries, routine immunizations, lab testing and minor procedures. Verbal consent will be obtained prior to each immunization. Vaccine information sheets are available upon request.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have had the opportunity to review a copy of the Notice of Privacy Practices which explains how your medical information will be used and disclosed. This is posted in the office and a copy is available upon request.

CARE EVERYWHERE CONSENT

Care Everywhere is a way to receive and send medical records electronically with other facilities that have the same medical records program. By signing below you authorize Park Cities Pediatrics to receive/send medical records when they are available or needed.

☐ I do **NOT** want to participate in Care Everywhere

ASSIGNMENT OF BENEFITS

I hereby assign Park Cities Pediatrics all right, title, and interest to any benefit payable for medical coverage. I direct that such benefits be paid directly to Park Cities Pediatrics and I will be responsible for any charges accrued and not paid by the insurance company. I am responsible for all co-pays, deductibles, co-insurance and non-covered services.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of my child's medical information by Park Cities Pediatrics to any consulting physician, hospital, and third-party payers such as insurance companies, government agencies, self insurance employer or utilization review organization.

This document remains in effect unless revoked in writing.

_____

Child's Name

X _____ _____

Signature of Parent/Guardian **Date**

8215 Westchester, Suite 150 • Dallas, Texas 75225 • 214.361.7185 • www.parkcitiespediatrics.com

Park Cities Pediatrics

Matthew L. Simon, MD

8215 Westchester Dr Suite 150 Dallas, Texas 75225
Phone: 214-361-7185 Fax: 214-373-4841

PATIENT'S NAME: _____ **DATE OF BIRTH:** ____/____/____

(CHECK THE BOX THAT APPLIES)

[ ] **I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING THE DIAGNOSIS, RECORDS; EXAMINATION RENDERED TO ME AND CLAIMS INFORMATION. THIS INFORMATION MAY BE RELEASE TO THE FOLLOWING:**

1. _____
2. _____
3. _____

[ ] **INFORMATION IS NOT TO BE RELEASED TO ANYONE.**

SIGNED: _____ **DATE:** _____

WITNESSED: _____ **DATE:** _____

****THIS RELEASE WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING.**

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.**