DATE:

PATIENT NAME:

DATE OF BIRTH:

SOCIAL SECURITY NUMBER:

I am currently taking the following medications:

I am allergic to the following medications:

_____

Patient Printed Name

_____

Patient Signature

I confirmed the same with the patient

_____

Office Nurse

PATIENT INFORMATION SHEET

Patients Name:_____ DOB_____
(Last) (First) (Middle)

Mailing Address:_____ City_____ State_____ Zip_____

Physical Address:_____ City_____ State_____ Zip_____

Home Phone:_____ Cell#:_____ Work:_____

Marital Status:_____ Race:_____ Student_____ Occupation_____

Employer's Name:_____ Address:_____

Spouse/Parents Name:_____ Address:_____

Employer of Spouse/Parent:_____ Phone#:_____

Name Of Insured:_____ DOB_____

Insured's Address:_____ Insured's Phone#_____

Emergency Contact

Name:_____ Address:_____

Phone:_____ Work/Cell#_____

Assignment of Benefits

I authorize payment of medical benefits to: Jasper Diagnostic Clinic

X_____ _____
(patients/guardians signature) Date

Release of Information

I authorize the release of any information necessary to process this claim or any future claims.

I hereby consent to diagnosis and treatment in this Clinic:_____Yes_____No

X_____ _____
(patients/guardians signature) Date

THIS MUST BE COMPLETEY FILLED OUT BEFORE YOU ARE TREATED IN THIS CLINIC

Authorization Form
For Release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below:

Patient Name:_____
DOB:_____
SS#:_____

The health information you may release subject to this authorization is as follows:

_____
_____
_____

Release my protected health information to the following person(s)/entity:
Name:_____

Street:_____

City:_____ **State:**_____ **Zip:**_____

The reasons or purposes for this release of information are as follows:

_____
_____
_____

The authorization shall be in force and effective until the following event and/or date:

X_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice:

Tele (409) 383-1355 Fax (409) 384-7276

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Patient Name: _____

DOB: _____ SS# _____

HIV/ AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records: Initial: _____ Date: _____

Limitatations on the information you may release subject to this Release Form are as follows:

_____

_____

_____

Release my protected health information to the following person(s)/entity:

Name: **Jasper Diagnostic Clinic** Tele: **409-383-1355**

Street: **300 Marvin Hancock Drive** Fax: **409-384-7276**

City: **Jasper** State: **TX** Zip: **75951**

The reasons or purpose for this release of information are as follows:

_____

_____

_____

Patient signature (or parent, guardian or legal representative):

_____

Date: _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to the fees set forth by the Texas State Board of Medical Examiners.

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

TEXAS IMMUNIZATION REGISTRY (ImmTrac2)
ADULT CONSENT FORM

(Please print clearly)

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ Telephone ( ) _____ Email address _____ Gender: ☐ Female ☐ Male

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

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

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 family 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.*

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 am a FIRST RESPONDER. ☐ I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) 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 _____

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.

Stock No. F11-13366

Revised 07/2019

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

Texas Immunization Registry (ImmTrac2)
Disaster Information Retention Consent Form

A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) ___/___/___ Gender: ☐ 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) has been designated as the disaster-related reporting and tracking system for immunizations, antivirals, and other medications administered to individuals in preparation for, or in response to, a disaster or public health emergency. From the time the event is declared over, the Texas Immunization Registry will retain disaster-related information received from health-care providers for a period of five (5) years. At the end of the five (5) year retention period, client-specific disaster-related information will be removed from the Texas Immunization Registry unless consent is granted to retain the client information in the Texas Immunization Registry beyond the five (5) year retention period. For more information, see Texas Health and Safety Code Sec. 161.00705. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Consent for Retention of Disaster-Related Information and Release of Information to Authorized Entities

I understand that, by granting the consent below, I am authorizing retention of my (or my child's) disaster-related information by DSHS beyond the five (5) year retention period. I further understand that DSHS will include this information in the Texas Immunization Registry. Once in the Texas Immunization Registry, my (or my child's) disaster-related information may by law be accessed by: a state agency, for the purpose of aiding and coordinating communicable disease prevention and control efforts, and/or a physician or other health-care provider legally authorized to administer immunizations, antivirals, and other medications, for treating the client as a patient; I understand that I may withdraw this consent to retain information in the Texas Immunization Registry beyond the five (5) year retention period and my consent to release information from the Texas Immunization Registry, at any time by written communication to the Texas Department of State Health Services.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization 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.

Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ **I am a FIRST RESPONDER.** ☐ **I am an IMMEDIATE FAMILY MEMBER of a First Responder.**

By my signature below, I GRANT consent to retain my disaster-related information (or my child's information, if younger than age 18) in the Texas Immunization Registry beyond the 5 year retention period.

Client (or parent, legal guardian, or managing conservator):

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 on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **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