PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

_____
Patient

_____
Date

_____
Print Name

_____
D.O.B

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations

(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

PATIENT REGISTRATION

Melecio Apostol, M.D.

CHILD INFORMATION

Child's name _____ DOB _____ Sex [ ] M [ ] F
Address _____
City _____ State _____ Zip _____

PARENT INFORMATION

Father's name _____ DOB _____ SS# _____
Employer _____ Occupation _____
Phone numbers: Home _____ Work _____ Cell _____

Mother's name _____ DOB _____ SS# _____
Employer _____ Occupation _____
Phone numbers: Home _____ Work _____ Cell _____

Does the child live with the above? [ ] Both [ ] Father [ ] Mother [ ] Neither
If neither, please provide the following information about the person with whom the child resides:
Name _____
Employer _____ Occupation _____
Phone numbers: Home _____ Work _____ Cell _____
Relationship to child _____

Emergency Contact

Who may we contact if the parents/guardians are not available?
Name _____
Phone numbers: Home _____ Work _____ Cell _____
I authorize the release of medical information to the individual above.
Signature _____ Date _____

INSURANCE

Primary insurance company name _____
ID number/Group number (if applicable) _____
Guarantor _____ DOB _____ SS# (if not above)
_____
Secondary insurance company name _____
ID number/Group number (if applicable) _____
Guarantor _____ SS# (if not above) _____

INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process any insurance claim made by this office. This authorization may be revoked by either me or the insurance company at any time in writing. I request that payment from my insurance company be made directly to Dr. Apostol or Rockport Pediatrics.

I certify that the information provided above is correct.

Signature _____ Date _____

Sandcastle Pediatrics Melecio F. Apostol, M.D., F.A.A.P.

PATIENT HISTORY

General Information

First Name _____ Middle Name _____
Last Name _____ DOB ____ / ____ / ____ Sex ( ) M ( ) F

Birth History

Hospital _____ Birth weight _____
City _____ State _____ Country _____
Any problems during pregancy? _____
_____
Tobacco use during pregnancy? ( ) N ( ) Y amount _____
Alcohol use during pregancy? ( ) N ( ) Y amount _____
Recreational drug use? ( ) N ( ) Y type _____
Any problems after birth? _____
_____

Growth and Development

At what age did your child: sit without support _____ walk _____
drink from a cup _____ speak in sentences _____
Any concerns regarding growth or development? _____
_____
Name of (pre)school/daycare _____ Grade _____
Any concerns regarding school performance? _____
_____

Medical History

Please check if your child has/has had any of the following conditions:

( ) Allergies
( ) Asthma
( ) Recurrent coughing
( ) Heart problems
( ) Constipation or diarrhea
( ) Recurrent abdominal pain
( ) Diabetes
( ) Seizures/Epilepsy
( ) Recurrent headaches
( ) Hearing problems
( ) Vision problems
( ) Behavior problems

Does your child have any other chronic or recurrent medical problems? _____
_____
Hospitalizations, including date and diagnosis _____
_____
_____
Surgeries, including type and date _____
_____
Medications _____
Allergies and reactions _____
Are your child's immunizations up to date? ( ) Y ( ) N If not, what is needed? _____
_____

Family History

Mother's age _____ Health problems _____
Father's age _____ Health problems _____
Age of siblings _____ Sex _____ Health problems _____
_____ Sex _____ Health problems _____
_____ Sex _____ Health problems _____
_____ Sex _____ Health problems _____
_____ Sex _____ Health problems _____

Are these the biological parents? ( ) Y ( ) N If not, please explain _____
_____

Please check if your child's primary relatives (including grandparents, aunts, uncles, and first cousins) have had any of the following, and if yes, please identify the relative:

( ) Heart attack/heart disese diagnosed prior to 45 yrs of age _____
_____
( ) Diabetes _____
( ) Cancer _____
( ) Seizures/Epilepsy _____
( ) Asthma _____
( ) Allergies _____
( ) Urinary tract infections as children _____
( ) Cystic fibrosis _____
( ) Muscular dystrophy _____
( ) Blood disorder _____
( ) Deafness _____
( ) Mental retardation _____
( ) Depression/any type of psychiatric disorder _____
_____
( ) Other problems _____

Any other concerns regarding your child? _____
_____
_____

How did you hear about us?

( ) Relative/Friend/Acquaintance If so, who? _____
( ) Newspaper If so, which one? _____
( ) Phone book If so, which one? _____
( ) School/Daycare If so, which one? _____
( ) Church If so, which one? _____
( ) Just passing by/saw sign _____

Signature _____ Date _____

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

ImmTrac Texas Immunization Registry

DEPARTAMENTO ESTATAL DE SERVICIOS DE SALUD
REGISTRO DE INMUNIZACIÓN (ImmTrac)
FORMULARIO DE CONSENTIMIENTO

(Please print clearly / Sirvase escribir claramente con letra de molde)

For Clinic/Office Use

Child's Last Name / Apellido del niño(a)

Child's First Name / Nombre del niño(a)

Child's Middle Name / Segundo nombre del niño(a)

Child's Date of Birth / Fecha de nacimiento del niño(a)

**Children under 18 years only / Solamente niños menores de 18 años*

Child's Gender / Género: ☐ **Male** / Masculino ☐ **Female** / Femenino

Child's Address / Dirección del niño(a)

Apartment # / Apartamento #

Telephone / Teléfono

City / Ciudad

State / Estado **Zip Code** / Código postal

County / Municipio

Mother's First Name / Nombre de la madre

Mother's Maiden Name / Nombre de soltera de la madre

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services. 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.

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

El Departamento Estatal de Servicios de Salud le anima a participar voluntariamente en el registro de inmunización de Texas.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that by granting consent below, I register my child in the Texas Department of State Health Services immunization registry and authorize the registry to include my child's information in the registry and to release past, present, and future immunization records on my child to a parent of the child and any of the following:

- public health district or local health department;
- physician or health care provider;
- insurance company, health maintenance organization or payor;
- school or child care facility in which the child is enrolled and/or
- state agency having legal custody of the child.

I understand that I may withdraw the 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, Immunization Registry, 1100 West 49th Street, Austin, Texas 78756.

Consentimiento Para Registrar al Niño(a) y Para Poder Dar a Conocer a Entidades Autorizadas el Récord de Inmunizaciones del Niño(a)

Entiendo y acepto que al autorizar mi consentimiento en la parte inferior, registro a mi niño(a) en el registro de inmunización del Departamento Estatal de Servicios de Salud de Texas y autorizo al registro para que incluya la información de mi niño(a) en el registro y que el récord de inmunizaciones de mi niño(a) del pasado, presente y futuro sea dado a conocer a alguno de los padres del niño(a), y a cualquiera de los siguientes:

- distrito de salud pública o departamento de salud local;
- médico o proveedor de atención de salud;
- compañía de seguros, organización para el mantenimiento de salud o pagador;
- escuela o centro de cuidado de niños, en el que el niño(a) está inscrito y/o
- agencia estatal que tenga custodia legal del niño.

Reconozco y acepto que en cualquier momento puedo retirar mi consentimiento de poder incluir la información de mi niño(a) en el Registro ImmTrac, y también retirar mi consentimiento para poder dar a conocer la información del registro, por medio de comunicación escrita dirigida al Texas Department of State Health Services, Immunization Registry, 1100 West 49th Street, Austin, Texas 78756.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.
Al firmar abajo, YO **AUTORIZO el consentimiento** para registrarlo. Deseo **INCLUIR** la información de mi niño en el registro de inmunización de Texas.

Parent, legal guardian, or managing conservator:
Alguno de los padres, tutor legal o administrador de bienes:

Printed Name / Escriba con letra de molde

Date / Fecha

Signature / Firma

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)

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.state.tx.us para más información sobre la Notificación sobre privacidad. (Referencia: *Government Code*, sección 552.021, 552.023, 559.003 y 559.004)

Questions? / ¿Tiene preguntas? (800) 252-9152 • (512) 458-7284 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac Group – MC 1946 • 1100 West 49th Street • Austin, TX 78756

Stock No. C-7
Revised 06/15/06

TEXAS Department of State Health Services

***PROVIDERS REGISTERED WITH ImmTrac** – please fax this **signed** (by parent) Consent Form to ImmTrac **only if the child is not** currently registered with ImmTrac.*
Fax to: Toll free (866) 624-0180