



COVID-19 Vaccine Release Form

Date: _____ Recipient Name: _____

Date of Birth: _____ Primary Care Provider: _____

Address: _____ City: _____ State: _____

Phone: _____ Emergency Contact & Phone: _____

COVID-19 VACCINE CONSENT (18 YEARS OF AGE AND OLDER)

Please Initial Each Item:

_____ I have been informed that the COVID-19 vaccine is an unapproved vaccine that has been authorized for use by the FDA under Emergency Use Authorization.

_____ I have received the "Fact Sheet for Recipients and Caregivers."

_____ I understand that the COVID-19 vaccine is not mandatory.

_____ I understand the significant known and potential risks and benefits of the COVID-19 vaccine, and the extent to which such risks and benefits are unknown.

_____ I have been notified about available alternative vaccines and the risks and benefits of those alternatives.

_____ I have not had a positive SARS-CoV-2 test within the past 90 days.

_____ I do not require the use of emergency medications, such as an Epi-Pen, for the treatment of severe allergies, including anaphylaxis.

Patient or Parent/Caregiver

Date

RD: _____ LD: _____ RT: _____ LT: _____ Nurse (print name): _____

LOT# _____ Signature: _____

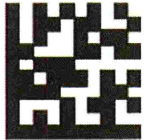
Expiration: _____ Date: _____



TEXAS
Health and Human
Services

Texas Department of State
Health Services

ImmTrac2 Immunization Registry
DISASTER INFORMATION
RETENTION CONSENT FORM



(Please print clearly)

Client's Last Name

Client's First Name

Client's Middle Name

Client's Date of Birth

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

Client's Gender: ☐ Male ☐ Female

Client's Address

Apartment #

Client's Telephone

City

State

Zip Code

County

Mother's First Name (if client is younger than 18 years of age)

Mother's Maiden Name (if client is younger than 18 years of age)

ImmTrac2, the Texas immunization registry, 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, ImmTrac2 will retain disaster-related information received from health-care providers for a period of 5 years. At the end of the 5 year retention period, client-specific disaster-related information will be removed from the Registry unless consent is granted to retain the client information in ImmTrac2 beyond the 5 year retention period.

The Texas Department of State Health Services (DSHS) encourages your voluntary participation in the Texas immunization registry.

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 5 year retention period. I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, 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 ImmTrac2 Registry beyond the 5 year retention period and my consent to release information from the Registry, at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

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:

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)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com • ImmTrac2 DC
Texas Department of State Health Services • ImmTrac2 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.

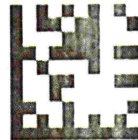
DO NOT fax to ImmTrac2. **Retain this form in your client's record.**



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 _____		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Date of Birth (mm/dd/yyyy) _____	Telephone (_____) _____		Email address _____		
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)

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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.