ENCOUNTER DATE	
MRN NUMBER	
IMMTRAC ID	

Harris County Public Health
Building a Healthy Community

ADULT: 19YRS AND OLDER

IMMUNIZATION INTAKE FORM

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE NAME:

DATE OF BIRTH: _____ /_____ /_____ MM DD YYYY	AGE:	LANGUAGE: ☐ English ☐ Spanish ☐ Other: _____

ADDRESS:	CITY:	STATE:	ZIP:

HOME PHONE #:	MOBILE #:	EMAIL:

SEX AT BIRTH: ☐ Male ☐ Female ETHNICITY: ☐ Hispanic ☐ Not Hispanic

GENDER: ☐ Male ☐ Female ☐ Non-Binary ☐ Questioning ☐ Transgender ☐ Other ☐ Choose Not to Disclose

RACE: ☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other

NATIONALITY (COUNTRY OF ORIGIN):	MARITAL STATUS:
MOTHER'S MAIDEN NAME:	MOTHER'S FIRST NAME:

DOES THE PATIENT HAVE HEALTH INSURANCE? (PRIVATE INSURANCE, MEDICAID, CHIP OR MEDICARE) ☐ Yes ☐ No

PARENT OR GUARDIAN INFORMATION FOR AGES 0-17 YEARS OLD:

LAST NAME:	FIRST NAME:	
DATE OF BIRTH: _____ /_____/_____ MM DD YYYY	RELATIONSHIP:	PHONE NUMBER:

CONSENT FOR IMMUNIZATION

READ, SIGN AND DATE:

I received a copy and read, or had explained to me, the information contained in the appropriate "COVID-19 Vaccine Fact Sheet"/ "Vaccine Information Statement (VIS)" about the disease(s) and vaccine(s) indicated for each vaccine that will be given today. I had a chance to ask questions which were answered to my satisfaction. I believe that I understand the benefits and risks of the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request. The doctor or clinic may keep this record in your medical file or your child's medical file. I received a copy of the Harris County Public Health Notice of HIPAA Privacy Practices. I freely and voluntarily give my signed permission for the vaccine(s) to be administered to the person listed above.

Signature of Patient, Parent or Guardian: _____ Date: _____

Note: Parents or guardians' signature is required if vaccine recipient/patient is 17 years old or younger

CLINIC USE ONLY

ELIGIBILITY STATUS: ☐ TVFC ELIGIBLE ☐ ASN ELIGIBLE ☐ NOT ELIGIBLE- PRIVATE STOCK ONLY

_____
SCREENER'S INITIALS

VITALS

WEIGHT (LBS):	HEIGHT (FT, IN):	TEMPERATURE (F°):	BLOOD PRESSURE *(18 years of age and older):*	HEART RATE *(18 years of age and older):*

MEDICATIONS: *list below*	☐ NO ALLERGIES ☐ HAS ALLERGIES: *list allergy/reaction below:*

NURSE'S NOTE

NAME: _____

DATE OF BIRTH: _____

Harris County Public Health
Building a Healthy Community

CLINIC USE ONLY

VACCINES GIVEN

VACCINE	TRADENAME	MFR	NDC #	LOT #	EXP DATE	SITE	VIS DATE	STOCK SOURCE
COVID-19	☐ PFIZER	PFIZER						SF- PS
	☐ MODERNA	MODERNA						SF- PS
	☐ NOVAVAX (12Y+)	NOVAVAX						SF- PS
DTAP	☐ DAPTACEL	SANOFI						SF- PS
	☐ INFANRIX	GSK						SF- PS
DTAP/IPV/HEP B	☐ PEDIARIX	GSK						SF- PS
DTAP/IPV	☐ KINRIX	GSK						SF- PS
DTAP/HIB/IPV	☐ PENTACEL	SANOFI						SF- PS
DTAP/IPV/HIB/HEP B	☐ VAXELIS	MERCK						SF- PS
HIB	☐ ACTHIB	SANOFI						SF- PS
HPV	☐ GARDASIL	MERCK						SF- PS
HEP A	☐ HAVRIX	GSK						SF- PS
HEP A/B	☐TWINRIX	GSK						SF- PS
HEP B	☐ RECOMBIVAX HB	MERCK						SF- PS
	☐ ENGERIX-B	GSK						SF- PS
IPV	☐ IPOL	SANOFI						SF- PS
MCV4	☐ MENQUADFI	SANOFI						SF- PS
MMR	☐ MMR II	MERCK						SF- PS
MMRV	☐ PROQUAD	MERCK						SF- PS
MEN B	☐ TRUMENBA	PFIZER						SF- PS
	☐ BEXSERO	GSK						SF- PS
PCV	☐ PREVNAR 20	PFIZER						SF- PS
ROTAVIRUS	☐ ROTARIX	GSK						SF- PS
RSV	☐ BEYFORTUS	SANOFI						SF- PS
SMALLPOX/MPX	☐ JYNNEOS	BARVARIAN						SF- PS
TD	☐ TD VAX	GRIFOLS						SF- PS
	☐ TENIVAC	SANOFI						SF- PS
TDAP	☐ ADACEL	SANOFI						SF- PS
	☐ BOOSTRIX	GSK						SF- PS
VARICELLA	☐ VARIVAX	MERCK						SF- PS
FLU	☐ FLUARIX	GSK						SF- PS
	☐ FLUCELVAX	SEQIRUS						SF- PS
	☐ FLUAD	SEQIRUS						SF- PS

NURSE NAME AND TITLE_____ DATE_____

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

Texas Immunization Registry (ImmTrac2)
Adult Consent Form

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) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your immunization records. With your consent, your immunization information will be included in the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

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 the Texas Immunization Registry, 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 by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

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. 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*.

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 _____ 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

Texas Department of State Health Services
Immunizations

Stock No. F11-13366
Revised 02/2022

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 years. At the end of the five 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 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 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 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 five 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

Texas Department of State Health Services
Imunization Section

Stock No. F11-12956
Revised 01/2024

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

Adult Safety Net (ASN) program

ADULT ELIGIBILITY SCREENING RECORD

PURPOSE: To determine and record eligibility for the DSHS ASN program. A record of the eligibility status of adults receiving vaccine supplied by DSHS must be maintained either in hard copy by the clinic providing the service or in an electronic system such as TWICES. Hard copies must be maintained for five years. ASN eligibility screening and documentation of eligibility status must take place at each immunization visit to ensure eligibility status for the program.

Date of Screening: _____/_____/_____ (mm/dd/yyyy)

Name: _____ (Last) (First) (Middle initial)

Date of Birth: _____/_____/_____ (mm/dd/yyyy) **Gender:** ☐ Male ☐ Female **Veteran:** ☐ Yes ☐ No

Important Information for Former Military Service Members: **Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard may be eligible for additional benefits and services. For more information, please visit the Texas Veterans Portal at https://texvet.org/partners/texasgov.**

ASN Eligibility Criteria (please check only one box below):

☐ I declare that I qualify for vaccines through the ASN program because I do not have health insurance.

☐ I declare that I qualify for vaccines through Disaster Relief/Outbreak efforts. The CDC waived insurance status (insured or non-insured) for all disaster relief efforts.

Referring Provider: _____

Patient Signature: _____ **Date:** _____/_____/_____ (mm/dd/yyyy)

NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is eligible to receive ASN vaccines.

With few exceptions, you have the right to request and to 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 agency to correct any information that is determined to be incorrect. See www.dshs.texas.gov for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, and 559.004)

Texas Department of State Health Services
Immunization Section

Stock No. F11-12842
Revised 10/2024

NAME:

DATE OF BIRTH:

Harris County Public Health
Building a Healthy Community

General Consent

I consent and agree to receive medical/health services from the Harris County Public Health (HCPH).
I understand that this medical/health service may include:

Physical assessment	WIC/Nutritional	Diagnostic tests for genetic disorders
Mental health screening	Hemoglobinopathies	Anemia
Developmental screening	Lead Poisoning	Blood disorders
Family Planning	Pap Smears	Birth control measures
Sexually transmitted infection screening	HIV screening	Urinary disorders
Immunizations	Tuberculin skin tests	Chest x-rays
Case Management	Prescriptions	Sputum specimens and

Other program specific diagnostic tests and/or medical/health services, including Interpretation services and that my insurance may be billed for the medical/health services provided. ***Services provided based on organization's discretion.**

_____
Patient/Guardian Initials

PRIVACY NOTICE

_____
Patient/Guardian Initials

I have been given a copy of HCPH Privacy Notice, which includes the HIPAA Privacy Rule. The Notice has been explained to me. I understand that HCPH will use and disclose my Protected Health Information for treatment, billing and healthcare operations without my written authorization. I understand my rights as described in the Notice. I understand how to make a compliant if I feel my rights have been violated.

CONSENT FOR PHOTOGRAPH/VIDEOTAPING

_____
Patient/Guardian Initials

I consent and agree to photographic or videotaped images made of the above-named patient or myself.
I understand and agree that these images may be used for identification and treatment and/or educational purposes.

REQUIRED FOR ALL PATIENTS

I attest that the information I have provided on this form is accurate and correct to the best of my knowledge. I hereby give my informed consent to the areas initialed above. No warranty or guarantee has been made to me by the HCPH staff or contractors regarding the care or services that will be provided by HCPH. I certify that the services and care to be provided have been fully explained to me and my questions have been answered to my satisfaction.

I have provided an accurate translation of this information to the patient who has presented for medical services. The patient states that they understand the information and has had an opportunity to have questions answered and voluntarily consents.

_____ _____ _____ _____
Full Signature of Patient/Parent or Legal Guardian | Date | Signature of Translator | Date

_____ _____
Relationship to Patient | Name of Translator

FOR HCPH STAFF USE ONLY

I witnessed the fact that the above-named patient (patient's parent or representation) received and has read the information contained in this consent form and was given the opportunity to ask questions, and signed this form.

_____ _____ _____
Name of Healthcare Provider | Healthcare Provider Signature *(Electronic Signature Where Applicable)* | Date

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that HCPH collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the agency to correct any information that is determined to be incorrect. For further information, contact Harris County Public Health – Health Information Services at 832-927-7647 or 832-927-7646.

Screening Checklist for Contraindications to Vaccines for Adults

YOUR NAME _____

DATE OF BIRTH ____/____/____ (month / day / year)

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means we need to ask you more questions. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccine?	☐	☐	☐
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	☐	☐	☐
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☐	☐
11. Are you pregnant?	☐	☐	☐
12. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
13. Have you ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
14. Are you anxious about getting a shot today?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Screening Checklist for Contraindications to Injectable Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH ____/____/____
month day year

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain Barré Syndrome?	☐	☐	☐
5. Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
6. Is the person to be vaccinated anxious about getting a shot today?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Place Patient Label Here

Harris County Public Health
Building a Healthy Community

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

About This Notice

This notice tells you about your privacy rights, Harris County Public Health's (HCPH's) duty to protect the health information that identifies you, and how HCPH may use or disclose health information that identifies you without your written permission. This notice does not apply to health information that does not identify you or anyone else.

Your Rights

You have the right to:

- Request a restriction on certain uses and disclosures of your information. However, HCPH is not required to agree to a requested restriction.
- Receive confidential communications of protected health information.
- Inspect and obtain a copy of your health record. HCPH may charge a reasonable fee to cover costs.
- Request changes to your health record. Requests for changes must be in writing.
- Obtain an accounting of disclosures of your health information.
- Request communications of your health information by alternative means or at alternative locations. For example, only send appointment messages by mail, no telephone messages.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken. Revocations must be in writing.

HCPH's Duty to Protect Your Health Information

* HCPH is required by law to protect the privacy of your health information. This means that HCPH will not use or disclose your health information without your authorization except in the ways we explain to you in this notice. We must abide by this notice.

* HCPH will ask you for a written authorization to use or disclose your health information in ways other than those stated in this notice. If you give such an authorization, you may revoke it at any time, but HCPH will not be liable for uses or disclosures made before you revoked your authorization.

* If HCPH changes the content of this notice, the new notice will be made available at our facilities and on our website. www.hcphtx.org within 30 days of the effective date of the changed notice. The new notice will apply to all health information maintained by HCPH, no matter when we received or created the information.

How HCPH Uses and Discloses Your Information

1. Treatment

HCPH may use or disclose your health information to provide, coordinate, or manage health care or related services. This includes providing care to you, consulting with another health care provider about you, and referring you to another health care provider. For example, HCPH can disclose your health information to refer you to a high-risk clinic or a hospital for services. HCPH may also contact you to remind you of an appointment or to tell you about other health-related information that may be of interest to you.

2. Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

3. Payment

HCPH may use or disclose health information about you to pay or collect payment for your health care. For example, HCPH can use or disclose your health information to bill your insurance company, Medicaid, or other funding sources such as The Texas Department of Health, for health care provided to you.

Place Patient Label Here

Harris County Public Health
Building a Healthy Community

4. Health Care Operations

HCPH may use or disclose health information about you for health care operations. Health care operations include:

- Conducting quality assessment, improvement activities, training health-care professionals; and
- The general administrative activities of HCPHES.

5. Family Member, Other relative, or Close Personal Friend

HCPH may disclose health information about you to a family member, other relative or close personal friend when the health information is related to that person's involvement with your care or payment for your care and you have had an opportunity to stop or limit the disclosure before it happens.

6. Health Oversight Activities

HCPH may sometimes use or disclose health information about you for health oversight activities. Health oversight activities include audits, inspections, and investigations of possible fraud.

7. Public Health

HCPH may disclose health information about you to a public health authority for purposes of preventing or controlling disease, injury, or disability, or to report vital statistics; and problems with FDA-regulated products or activities.

8. Victims of Abuse, Neglect, or Domestic Violence

If HCPH believes you are the victim of abuse, neglect, or domestic violence we may disclose health information about you to a governmental agency that requires reports of abuse, neglect, or domestic violence as mandated by Texas law.

9. Serious Threat to Health or Safety

HCPH may use or disclose health information about you if we believe the use or disclosure is needed to prevent or lessen a serious and immediate threat to the health and safety of a person or the public.

10. As Required by Texas Law

HCPH may use or disclose health information about you when a law requires the use or disclosure.

11. Contractors

HCPH may disclose health information about you to a contractor if the contractor needs the information to perform services for us and agrees to protect the privacy of your information.

12. Purposes Relating to Death

HCPH may disclose health information about you to hospitals for the purpose of organ transplants, coroners, medical examiners, and funeral directors.

13. Research

HCPH may use or disclose health information about you for research if the HCPH Research Review Committee approves the use. The committee will ensure that your privacy is protected when your health information is used in research.

14. HCPHES Does Not Use Your Information For Marketing Purposes.

Complaint Process

If you believe that HCPH has violated your privacy rights, you have the right to file a complaint within 180 days of when you learned of the violation. Complaints can be filed with any of the agencies listed below.

- HCPH Privacy Officer at: 2223 West Loop South, Room 643, Houston, Texas 77027; Telephone: 713-439-6168
- Harris County Privacy Officer at: 1310 Prairie, Suite 200 Houston, Texas, 77002; Telephone: 713-755-5349;
- Region VI, Office of Civil Rights, U.S. Department of Health & Human Services, 1301 Young Street , Suite 1169, Dallas, Texas, 75202; Telephone: 214-767-4056

There will be no retaliation for filing a complaint. You can also file a complaint on-line at OCRComplaint@hhs.gov.

Effective Date: April 14, 2003

009- 091