

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 Nar	me
Date of Birth (mm/dd/yyyy) Gender:	☐ Male - ☐ Female Telephone	 Em:	ail address
Address			Apartment #/Building #
City	State	Zip Code County	
Mother's First Name Mother's Maiden Name			
Race (sel American Indian or Alaska Native Native Hawaiian or Other Pacific Island Recipient Refused		or African-American Race	Ethnicity (select only one) <ul> <li>Hispanic or Latino</li> <li>Not Hispanic or Latino</li> <li>Other</li> </ul>
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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. Visit Texas Health and Safety Code Sec. 161.00705 at statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705 for more information.			
<b>Consent for Retention of Disaster-Related Information and Release of Information to Authorized Entities</b> 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. <b>Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.</b>			
I am a FIRST RESPONDER.	I am an IMMEDIATE FA		•
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 manag	ing conservator):		
Printed Name	Signature		Date
<b>Privacy Notification:</b> 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. Visit dshs.state.tx.us/sites/default/files/hipaa/docs/DSHS-NPP-English-5-1-2022.pdf for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)			
<b>PROVIDERS REGISTERED WITH the Texas Immunization Registry:</b> Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. <b>DO NOT</b> fax to the Texas Immunization Registry. <b>Retain this form in your client's record.</b>			
Questions? Tel: 800-252-9152 • Fax: 512-7 Texas Department of State Health Services			try – MC 1946 • P. O. Box 149347 •

Texas Department of State Health Services Imunization Section

Austin, TX 78714-9347