AMIT P. PARIKH, D.O.
HOUSTON CENTER FOR FAMILY PRACTICE and SPORTS MEDICINE

# HOUSTON-HARRIS COUNTY IMMUNIZATION REGISTRY
# AUTHORIZATION FOR ELECTRONIC EXCHANGE / RELEASE OF IMMUNIZATION INFORMATION

I do hereby voluntarily consent to the electronic exchange / release of

_____ _____
Name of Patient Date of Birth

_____ _____
Medical Record # Social Security #

Immunization information to the following agencies:

TEXAS DEPARTMENT OF HEALTH
HARRIS COUNTY HOSPITAL DISTRICT
KELSEY-SEYBOLD MEDICAL GROUP, P.A.
AUTHORIZED PROVIDERS (Private Physicians, School Nurses, etc.)
TEXAS CHILDREN'S HOSPITAL INTEGRATED DELIVERY SYSTEM
HOUSTON DEPARTMENT OF HEALTH AND HUMAN SERVICES
HARRIS COUNTY PUBLIC HELATH and ENVIRONMENTAL SERVICES

Hereinafter individually referred to as a "Health Provider".

I understand that I am authorizing the electronic exchange / release of all immunization information to the health care providers for the purpose of continual medical care. The confidentiality of the data will be maintained within legal limits.

I further understand that the revocation or refusal to sign this exchange /a release will not change or prejudice my current or future health care from the Health Provider.

I understand that the health Provider, its employees, officers and physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

I understand that I have the right to revoke this authorization at any time with the understanding that all or part of the information may have been used in good faith prior to the revocation. I understand that my consent to this release of immunization information shall be effective until it is withdrawn in writing by me.

I have received written information about the electronic exchange and use of my immunization information and the extent of its use. I have had an opportunity to ask questions and to have my questions answered.

My signature on this consent form attests to the fact that my child _____
Has, within the limits imposed by age, child's assent (>12 years) maturity, and psychological state, given his/ her assent (affirmative agreement) to participate in this research project.

_____ _____
Date Signature of Patient / Parent / Guardian

_____ _____
Date Signature of Health Care Provider

**WITHDRAWAL OF WRITTEN CONSENT**

I withdraw my written consent previously given to the Houston-Harris County Immunization Registry to release my or my child's immunization information.

_____ _____
Signature of Patient / Parent / Guardian Date