Ravalli County Public Health
Prevent. Promote. Protect.
205 Bedford St Suite L, Hamilton, MT 59840-2853
Phone: (406) 375-6671 Fax: (406) 363-7540

CHECK LIST: 3RD PARTY AUTHORIZATION FORM

This form may be used if the parent/guardian is unable to accompany their child(ren) to Ravalli County Public Health Department for immunization services and are authorizing another adult to bring in their child(ren).

Parent/legal guardian must:

- ☐ Complete Registration form: Complete page 1
- ☐ Include a copy of a valid photo ID of the Parent/legal Guardian completing the forms
- ☐ Include a copy (front and back) of your child's insurance card or bring in the original
- ☐ Screening Questionnaire: Complete page 3 regarding the child's medical history, sign and date.
- ☐ Include current copy of your child's immunization record or have records faxed 406-363-7540
- ☐ Complete and sign 3rd Party Authorization Form
- ☐ The Authorized 3rd Party Adult must bring a valid photo ID
- ☐ Send all of the above information with the authorized 3rd party person presenting for the visit with your child

For staff only:

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REGISTRATION FORM

DATE: _____

Client Name (person receiving services):_____
Last First MI

Other names used: _____

Date of Birth :_____/_____/_____(mm/dd/yyyy) **Age**:___ **Primary Doctor**:_____

Mailing Address: _____

City: _____ **County**: _____ **State:** _____ **Zip:**_____

Parent/Legal Guardian Information:

_____
Last First MI DOB

_____
Last First MI DOB

Phone #:_____
Alternate phone #:_____

May we leave a detailed message on your phone? Yes ____ No ____

Relationship to client (circle): Mother Father *Other:
_____
If other: Legal Guardian/Authorized Representative (*documentation must be provided*)

INSURANCE INFORMATION: Please check box and provide a copy of your insurance card(s).

- ☐ NO INSURANCE
- ☐ HMK (BLUE CROSS/BLUE SHIELD)
- ☐ HMK+ (MEDICAID)
- ☐ PRIVATE INSURANCE

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Please select all services requested:

- ☐ Required vaccines to attend public school: (MMR, Varicella, DTaP/Tdap, Polio).
- ☐ Required vaccines to attend daycare: (MMR, Varicella, DTaP, HIB, PCV, Hepatitis B, Polio).
- ☐ Age-recommended vaccines (excluding influenza vaccine)
- ☐ Influenza vaccine
- ☐ Other _____

Acknowledgement and Consent: Please check each of the following boxes

- ☐ **Consent to trea**t: I authorize RCPH to administer treatment as deemed necessary for care of the patient named above. If applicable, I certify that I am the parent or legal guardian of the patient. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.
- ☐ **Assignment of Benefits:** I authorize payment of medical benefits to RCPH.
- ☐ **Privacy Notice:** I have reviewed a copy of the Notice of Privacy Practices, which provides a description of information uses and disclosures. I may request a copy of the Notice of Privacy Practices for my own records.

Parental/legal guardian consent for RCPH outpatient Immunization clinic services:

- I give permission for my child/dependent to be seen by nursing staff at RCPH indicated above. I understand that RCPH will inform me of any emergency regarding my child/dependent by phoning my contact telephone listed above.
- We understand that I (we) will be notified by telephone (at the contact number listed below) if other services are recommended, if there are questions or clarifications about medical history including immunizations, or in the event of an adverse reaction after receiving services.
- **ACCEPT OR DECLINE:** I authorize my health care provider and local public health agency to collect and enter my child's immunization records into the Department of Public Health and Human Services' immunization registry (imMTrax), a confidential computer system that contains immunization records. I understand that information in the registry may be released to local health departments, as well as my health care providers to assist in my or my child's medical care and treatment. In addition, information may be released to childcare facilities and schools in which my child is enrolled to comply with state requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department.

☐ **Accept imMTrax State Immunization Registy**
☐ **Decline imMTrax State Immunization Registy**

X

Signature of Parent/Legal Guardian Date:

This authorization expires 14 days from the date of signature.

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HEATLH SCREENING CHECKLIST

Client Name:_____ DOB:_____ Today's Date:_____

The following questions help us determine which vaccines your child may be given. If you answer, "yes" to any question, a nurse may contact you prior to administering the vaccine to your child. If you a question is unclear, please contact us to clarify at 406-375-6672.

	Please answer the following for the person receiving immunizations:
1.	Please list any allergies and the type of reaction (check all that apply): ☐ **No known allergies** ☐ Eggs ☐ Baker's Yeast ☐ Gelatin ☐ Latex ☐ Thimerosal ☐ Streptomycin ☐ Neomycin ☐ Casein ☐ Other (describe):
2.	Please list your current medications (or attach list): ☐ **None**
3.	Does the person getting the vaccine have any of the following health problems (check all that apply): ☐ **None** ☐ lung disease (ex: COPD, asthma, emphysema) ☐ liver disease (ex: cirrhosis, Hepatitis) ☐ alcoholism ☐ renal failure/dialysis ☐ metabolic disease ☐ diabetes ☐ asplenia ☐ cerebrospinal fluid leak ☐ cochlear implant ☐ heart disease (congestive heart failure, cardiomyopathies) ☐ seizures ☐ Guillain-Barre Syndrome ☐ encephalitis ☐ anemia or other blood disorder (sickle cell disorder, thrombocytopenia) ☐ other health condition (please describe):
4.	Does the person getting the vaccine have any immune system problems (check all that apply): ☐ **No** ☐ cancer ☐ leukemia ☐ HIV/AIDS ☐ organ or stem cell transplant ☐ Any other immune system problem (please describe):
5.	Does the person getting the vaccine (check all that apply): ☐ **No** ☐ smoke cigarettes ☐ use IV drugs
6.	**Females only**: Is the person getting the vaccine pregnant or breastfeeding or is there a chance of becoming pregnant during the next month? ☐ **N/A** ☐ No ☐ Yes (please describe):
7.	**Children 0-18 years only**: has the child, a sibling or parent ever had brain or other nervous system problem such as seizures or swelling of the brain? ☐ **N/A** ☐ No ☐ Yes (please describe):
8.	**Infants only**: have you ever been told that the infant getting the vaccine has had problems with their bowels (such as intussusception)? ☐ **N/A** ☐ No ☐ Yes (please describe):
9.	Is the person getting the vaccine sick today? ☐ No ☐ Yes (please describe):
10.	Has the person getting the vaccine ever had a serious reaction after receiving a vaccination? ☐ No ☐ Yes (please describe):
11.	Has the person getting the vaccine had any vaccines in the last 4 weeks? ☐ No ☐ Yes (please describe):
12.	In the past 3 months, has the person getting the vaccine ever (check all that apply): ☐ **No** ☐ Had treatment with anticancer drugs ☐ Taken medications that can weaken the immune system such as steroids (ex: Prednisone) or biologics (ex: Enbrel, Humira) for the treatment of certain conditions like rheumatoid arthritis, Crohn's disease or psoriasis
13.	In the past year, has the person getting the vaccine ever (check all that apply): ☐ **No** ☐ Received a transfusion of blood or blood products ☐ Received immune (gamma) globulin ☐ Currently getting or recently had radiation treatment ☐ Taken an anti-viral drug (such as Acyclovir, Famciclovir, Valacyclovir) ☐ Children 0-18 years on long-term aspirin therapy

_____

Signature of Parent/ Legal guardian Date:

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Authorized Individual

Please review the following information and authorization for immunizations or other clinic services when you cannot be present at the time of immunizations or services.

I (we) have the legal right to designate 3rd party authorization to the following individual to bring my child/dependent to RCPH to receive services.

Authorized Individual:_____
Last First MI

Relationship to patient:_____

Other names used: _____

Date of Birth :_____/_____/_____(mm/dd/yyyy) **Age**:___

Phone:_____

Address: _____

City: _____ **County**: _____ **State:** _____ **Zip:**_____

(The authorized 3rd party individual must bring a photo ID)

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you and/or your child may be used.
Please review it carefully.
The privacy of you and your child's health information is important to us.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program which requires that all medical records and other individually identifiable information used or disclosed by, Ravalli County Public Health Department, in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your personal health information is used.

Uses and disclosures of health information
We use and disclose health information about you for treatment, payment and healthcare operations. For example:

- Treatment: means providing, coordinating, or managing health care and related services by one or more health care providers. EX: a physical exam.

- Payment: we may use and disclose your health information to obtain payment for services we provide to you. EX: billing your insurance for payment.

- Healthcare operations: We may disclose your health information for healthcare operations, which include quality assessment and improvement activities, conducting training programs, accreditation, certification, licensing or credentialing activities. EX: quality assessment review.

How We Will Use or Disclose Personal Health Information Without Your Consent, Without Written Authorization or Without Opportunity to Object:

The following examples are other ways we may use and share your PHI or your child's without your consent, written authorization, or opportunity to object. By law, we are required to share your PHI or your child's in these instances:

- Public Health Communicable Disease Reporting
- Public Health Activities for preventing or controlling disease, injury or disability
- Abuse, Neglect, or Domestic Violence reporting (mandated reporters)
- Health Oversight activities
- Legal proceedings
- Law enforcement
- Harmful or Self- Harmful Activities

IMMUNIZATIONS AND/OR MATERNAL-CHILD HEALTH
When you sign the IMMTRAX CONSENT FORM, PHI concerning you or your child, which may be provided to the Health Department or recorded in the course of receiving immunizations is electronically recorded and retained in the Montana State Vaccine Registry, ImMTrax. This information can be released to Department of Public Health and Human Services, provider's offices, schools, and childcare providers.

Demographic information (*name, address, telephone number, date of birth, gender, race, ethnicity, primary care provider, education, marital status, pay source, employer etc.)* that is provided for immunization or maternal-child health purposes and may be shared among those programs for the purposes of making other appropriate services available to you.

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We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

All persons who have access to this information are obligated under federal and state law to protect the information from unreasonable and inappropriate disclosures.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorizations in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

YOUR RIGHTS

You have the following rights with respect to your PHI:

- The right to request restrictions or disclosures on certain uses of your information.
- The right to get a copy of your medical record.
- The right to ask us to correct health information that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we will tell you why in writing within 60 days.
- The right to request your PHI in specific manner. EX: home or office phone, different address.

In order to exercise any of these rights, you will be required to complete a form that we will provide to you upon request. We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI.

This notice is effective as of April 14th, 2003, and we are required to abide by the terms of the Privacy Notice currently in effect. We reserve the right to change the terms of our Privacy Notice and to make the new notice provisions effective for all PHI we maintain.

If you have any questions about this notice, the staff at Ravalli County Public Health will be happy to assist you with obtaining more information about our privacy practices.

If you would like to file a complaint, you may contact:

Ravalli County Attorney's Office
205 Bedford Street Suite C
Phone: 406-375-6750
Fax: 406-375-6731

For more information about HIPAA or to file a complaint with Health and Human Services:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll free 1-877-696-6775

Patient/Guardian Signature:_____Date:_____