



**ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
PUBLIC HEALTH DEPARTMENT**

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Patient Information Request Form
Alameda County Perinatal Hepatitis B Prevention Program

Date: _____
To: _____ Fax: _____
From: _____
[Sender is exempt from requiring authorization per HIPPA [citation 164.512 (b)]
Phone: **510-268-2085** Fax: **510-268-2111**
Number of pages (including cover sheet): 1

| | | |
|----------------|--------------|---------------|
| _____ | _____ | _____ |
| Name of Mother | Mother's DOB | Delivery Date |
| _____ | _____ | |
| Name of Child | Child's DOB | |

Please fax the information requested:

Gender of Baby: Male Female Name, if known: _____
Date of Birth: _____ Time of Birth: _____
Date of HBIG Injection: _____ Time of HBIG Injection: _____
Date of HBV Vaccine #1: _____ Time of HBV Vaccine #1: _____
(PEP report will be made if any information missed in above area)

Hepatitis B vaccine series dates given:
#1: _____ #2: _____ #3: _____ #4: _____

Post-vaccination Serology Record: (Please attach/fax lab results)
HBsAG test date: _____ Test result: _____
Anti-HBs test date: _____ Test result: _____

HBsAG positive report
 Update address: _____ **Phone number:** _____
 Next appointment: _____ **or no longer seen in your office since** _____
 Pediatrician name: _____ **Phone:** _____ **Fax:** _____
 Other: _____

 Name of person completing above information: _____

Alameda County Perinatal Hepatitis B Program (510) 268-2085

CONFIDENTIAL INFORMATION

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Note: Privacy Rule (HIPPA) permits covered entities to disclose PHI without authorization to public health authorities or other entities who are legally authorized to receive such reports for the purpose of preventing or controlling disease. This includes the reporting of disease, conducting public surveillance, investigations, or interventions.