TEXAS
Health and Human Services

Form H3037
April 2003-E

Report of Pregnancy

The Texas Health and Human Services Commission (HHSC) provides certain cash assistance and/or Medicaid coverage for low income pregnant women. To administer these programs, the department needs the information requested below. Please verify the items checked below and return the white copy of this form in the postage paid envelope provided.
THE DEPARTMENT CANNOT PAY YOU FOR COMPLETING THIS FORM. Thank you for your assistance.

Name of Patient	Case Name (if different)	Case No.

☐ Month Pregnancy Began .....

☐ Are multiple births anticipated? ..... ☐ Yes ☐ No

If yes, indicate the number anticipated: .....

☐ Date of Expected Delivery .....

☐ Should patient be exempt from working? ..... ☐ Yes ☐ No

Signature – Physician, Advanced Nurse Practitioner, RN, or Other Medical Professional (under physician's orders)

Date

Name (please type or print)

Title

☐ Physician ☐ Advanced Nurse Practitioner (includes certified nurse-midwife) ☐ Registered Nurse ☐ Other Medical Professional (under physician's orders): Specify:

Address	Telephone No.
Name of Supervising Physician	Telephone No.

Client complete page 2.

PLEASE RETURN TO:

Caseworker	Date
Office Address and Telephone No.	

Report of Pregnancy
Authorization to Release Medical Information

SECTION I

Patient's Name _____

HHSC is requesting verification of your medical needs to determine your eligibility for services. When you sign this authorization, you are giving HHSC permission to contact your doctors, medical facilities, or other health care providers to request copies of your health information as indicated below. Your signature is required on this authorization form to determine your eligibility for services.

I authorize _____ **to complete Form H3037, Report of Pregnancy.**
Doctor, Medical Facilities, or other Health Care Providers

This authorization expires on: _____

SECTION II

_____ _____
Client or Personal Representative's Signature **Date**

If you are signing for the client, please describe your authority to act for the client:

_____

_____

Note: If the person requesting the release of case information cannot sign his/her name two witnesses to his/her mark (X) must sign below:

_____ _____
Witness **Date**

_____ _____
Witness **Date**

SECTION III

Notice to Client

HHSC, a receiver of this information, will protect your personal health information in accordance with federal and state privacy regulations. If you authorize release of your health information to other parties it may no longer be protected by privacy regulations.

You can withdraw permission you have given your doctor or health care provider to use or disclose health information that identifies you, unless they have already taken action based on your permission. You must withdraw your permission in writing.