4201 Bee Caves Road, Suite C-100
Austin, TX 78746
Ph: 512.327.1155
Fax: 512.327.1156
www.schoolhousepediatrics.com

TRANSFER OUT

Authorization for Release and Disclosure of Protected Health Information

Indicate name of physician, hospital, medical center or lab that you are requesting records to be sent to:

To: ______________________________ Phone#: ______________________ Fax#: _____________________

Address: ________________________________ City/State/Zip: ___________________________________

I am requesting that the medical information for patient names (listed below) be transferred from:

Schoolhouse Pediatrics
4201 Bee Caves Road, Suite C-100
Austin, TX 78746

Please release the following information:

_____Problem List	_____Lab Reports	_____Immunization Record
_____Progress Notes	_____Medications	_____Specialist Reports
_____History & Physical Exam	_____X-Ray Reports	_____All Records

This information is necessary for the following purpose:

_____Continued Patient Care	_____Personal Use	_____Attorney / Legal
_____Insurance	_____Other (Specify)	

Patients' medical records are being requested for:

Name: ____ Date of Birth: _____________________

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Name: ____ Date of Birth: _____________________

Name: ____ Date of Birth: _____________________

I understand that the information in my child's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. *I authorize these records to be released from Schoolhouse Pediatrics and agree to the $25.00 (per child) medical records release fee.*

Signed: _______________________________ Relationship: ________________ Date: ______________