



4201 Bee Caves Road, Suite C-100  
Austin, TX 78746  
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[www.schoolhousepediatrics.com](http://www.schoolhousepediatrics.com)

### TRANSFER IN

#### Authorization for Release and Disclosure of Protected Health Information

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

To: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

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

Dr. Elizabeth Reidy  
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                      \_\_\_\_ Other (Specify) \_\_\_\_\_

This information is necessary for the following purpose:

\_\_\_\_ Continued Patient Care                      \_\_\_\_ Personal Use                      \_\_\_\_ Attorney / Legal  
\_\_\_\_ Insurance                      \_\_\_\_ Other (Specify)

Patients to be established:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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 faxed to 512.327.1156.**

Signed: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_