



Treehouse Pediatrics
 15930 Great Oaks Dr., Bldg. B
 Round Rock, TX 78681
 Office (512) 255-8868
 Fax (512) 255-8869

Anselmo Unite, M.D. Debaroti Addy, M.D. Ting- Chuan Chang, M.D. Wade Travis, M.D.

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# _____

Address: _____ Fax# _____

City/State/Zip: _____

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

Treehouse Pediatrics
 15930 Great Oaks Dr., Bldg B
 Round Rock, TX 78681

Please release the following information:

- | | | |
|--|--|--|
| <input type="checkbox"/> Problem List | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Medications | <input type="checkbox"/> Specialist Reports |
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Other (Specify) |

This information is necessary for the following purpose:

- | | | |
|---|--|---|
| <input type="checkbox"/> Continued Patient Care | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Attorney/Legal |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Other (Specify) | |

Establishing with: _____ Dr. Unite _____ Dr. Addy _____ Dr. Chang _____ Dr. Travis

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

Signed _____ Relationship _____ Date _____