



**Treehouse Pediatrics**  
**15930 Great Oaks Dr., - B**  
**Round Rock, TX 78681**  
**Office # 512-255-8868**  
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**Ting – Chuan Chang, M.D.**

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**TRANSFER OUT**  
***Authorization for Release and Disclosure of Protected Health Information***

In accordance with state law and regulatory agency requirements, the health record is the property of Treehouse Pediatrics. **A prepayment of \$15.00 per chart for copying and postage is required before the request can be processed. (A family limit of \$25.00 will be applied to 2 or more records.)**

I hereby authorize Treehouse Pediatrics Medical Records Custodian to release information from the medical records of:

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Information May Be Released To:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

**Information May Be Released From:**

**Treehouse Pediatrics**

**15930 Great Oaks Dr., Bldg. B**

**Round Rock, TX 78681**

Please release the following information:

\_\_\_\_ Problem List  
 \_\_\_\_ Progress Notes  
 \_\_\_\_ History & Physical Exam

\_\_\_\_ Lab Reports  
 \_\_\_\_ Medications  
 \_\_\_\_ X-Ray Reports

\_\_\_\_ Immunization Record  
 \_\_\_\_ Specialist Reports  
 \_\_\_\_ Other (Specify)

This information is necessary for the following purpose:

\_\_\_\_ Continued Patient Care  
 \_\_\_\_ Insurance

\_\_\_\_ Personal Use  
 \_\_\_\_ Other (Specify)

\_\_\_\_ Attorney/Legal

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: \_\_\_\_\_