Jollyville Pediatrics
11851 Jollyville Road, Suite 204
Austin, Texas 78759
Phone: 512.219.5550
Fax: 512.219.5551

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: _____

City/State/Zip: _____

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

❑ **Nitzia Cepeda, MD, FAAP** ❑ **Evelyn Spencer, MD, FAAP**
Jollyville Pediatrics
11851 Jollyville Road, Suite 204
Austin, Texas 78759

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)	

Establishing with: ❑ **Nitzia Cepeda, MD, FAAP** ❑ **Evelyn Spencer, MD, FAAP**

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: _____