



Kathleen Stinson, MD, FAAP
Tesa Stark, RN, CPNP
331 Sportsplex Dr, Suite C
Dripping Springs, TX 78620
512-894-3737 512-894-3738 fax

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:

Dripping Springs Pediatrics
331 Sportsplex Dr., Suite C
Dripping Springs, Texas 78620

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. Kathleen Stinson

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: _____