



**REQUEST FOR TRANSFER OF HEALTHCARE RECORDS TO:  
BOERNE PEDIATRICS**

124 E Bandera RD, Suite 304  
Boerne, Texas 78006  
830-816-5055  
FAX 830-816-5056

Today's Date \_\_\_\_\_

Patients Name: \_\_\_\_\_ DOB \_\_\_\_\_

Patients Name: \_\_\_\_\_ DOB \_\_\_\_\_

Patient's Address \_\_\_\_\_

Previous Physician office: \_\_\_\_\_

Office Phone: \_\_\_\_\_ FAX \_\_\_\_\_

**\* Please send Immunization Records via fax ASAP and Medical Records within 4 weeks.**

**Please check type of information to be released:**

Complete Health Record  History and Physical Exam  Lab Test Results  Progress Notes  Other (specify)

**Purpose of Request:**

Treatment or consultation  At the request of the patient

**Drug and or Alcohol and/or Psychiatric, and/or HIV/AIDS Records Release**

I understand that the requested information may contain reference to or results of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information. I authorize the release of such confidential information to the indicated party, unless prohibited in my instructions above.

**Time Limit & Right to Revoke Authorization**

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Boerne Pediatrics 124 E Bandera Rd Ste 304. Boerne TX. 78006. Unless revoked, this authorization will expire 180 days from date of signature.

**Re-disclosure**

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer by protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

**Signature of Patient or Personal Representative Who May Request Disclosure**

I hereby authorize the release and transfer of my child's complete medical record to Boerne Pediatrics. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can view or receive a copy of the protected health information to be used or disclosed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Identity of requestor verified  Photo ID  Matching Signature  
 Other (specify)

Verified by: \_\_\_\_\_