

BLUE FISH

P E D I A T R I C S
www.bluefishmd.com

Transfer of Medical Records Authorization (Woodlands)

Please send information including diagnosis and records of any treatment or examination rendered to patient _____, DOB _____.

TO:
Blue Fish Pediatrics - Woodlands
920 Medical Plaza Dr., Suite 530
Shenandoah, TX 77380
Fax: 832-562-2007

FROM:
Blue Fish Pediatrics - Woodlands
920 Medical Plaza Dr., Suite 530
Shenandoah, TX 77380
Fax: 832-562-2007

FROM: _____

TO: _____

Reason for Transfer:

- Moving to a new area
- Change of insurance plan
- Patient has outgrown pediatric age
- Transferring care to new pediatrician due to:
 - Medical care of child(ren)
 - Wait time in office
 - Difficulty scheduling timely appointments
 - Interactions with office staff
 - Other: _____

Comments: _____

I hereby authorize you to release information including the diagnosis and records of any treatment or examination rendered to _____ during the period from _____ to _____ to Blue Fish Pediatrics, LLP. I am aware that the records released may contain information relating to psychiatric or psychological testing, physical testing, physical abuse, or drug and alcohol abuse.

I hereby authorize you to release HIV/HTVL/AIDS test results: YES NO

Guardian Signature

Date

Witness

Date