BLUE FISH

PEDIATRICS

www.bluefishmd.com

Transfer of Medical Records Authorization (Greater Heights)

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

□ TO:
Blue Fish Pediatrics Greater Heights
1900 N. Loop W, Suite 100
Houston, TX 77018
Fax: 713-467-1104

□ FROM:
Blue Fish Pediatrics Greater Heights
1900 N. Loop W, Suite 100
Houston, TX 77018
Fax: 713-467-1104

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