

# BLUE FISH

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

## Transfer of Medical Records Authorization (Sienna Plantation)

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

TO:  
Blue Fish Pediatrics Sienna Plantation  
8780 Hwy 6, Suite A  
Missouri City, TX 77459  
Fax:

FROM:  
Blue Fish Pediatrics Sienna Plantation  
8780 Hwy 6, Suite A  
Missouri City, TX 77459  
Fax:

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