BLUE FISH

PEDIATRICS

www.bluefishmd.com

Transfer of Medical Records Authorization

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

□ TO: Blue Fish Pediatrics
8780 Highway 6, Suite A
Missouri City, TX 77459
Phone: 832-623-7500
Fax: 832-623-7501

FROM: _____
_____
_____
_____

□ FROM: Blue Fish Pediatrics
8780 Highway 6, Suite A
Missouri City, TX 77459
Phone: 832-623-7500
Fax: 832-623-7501

TO: _____
_____
_____
_____

Reason for Transfer:

- □ Moving to a new area
- □ Change of insurance product
- □ Patient has outgrown pediatric age
- □ Transferring care to new pediatrician due to:
  - □ Medical care of child(ren)
  - □ Wait time in office
  - □ Difficulty scheduling timely appointment
  - □ 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 Shannon Crane, M.D. and David Deray, M.D. 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

_____ _____
Signature Date

_____ _____
Witness Date