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
915 Gessner, Suite 525
Houston, TX 77024
Fax: 713-467-0536

FROM: _____

_____

_____

_____

□ FROM: Blue Fish Pediatrics
915 Gessner, Suite 525
Houston, TX 77024
Fax: 713-467-0536

TO: _____

_____

_____

_____

Reason for Transfer:

- □ Moving to a new area
- □ Change of insurance product
- □ Patient has outgrown pediatric age
- □ Transfering care to new pediatrician due to:
  - □ Medical care of child (ren)
  - □ Wait time in office
  - □ Difficulty scheduling timely appointment
  - □ Interactions with office staff
  - □ Other:
  - □ Needs Specialist Notes

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/from Peter Jung, M.D., William C. Pielop, M.D., Secily Torn, M.D., Amanda Brack, M.D., N. Eric Lindsay, M.D., Katherine Lusk, M.D., and Elizabeth Hall, M.D., Jenna Penland, M.D., Michelle Tedja, 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

_____ _____

Guardian Signature Date

_____ _____

Witness Date