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 Greater Heights
1900 N. Loop West, Suite 100
Houston, TX 77018
Fax: 713-467-1104

FROM: _____

_____

_____

_____

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

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
  - □ Needs Specialist Notes
  - □ 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/from 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