

BLUE FISH

P E D I A T R I C S

www.bluefishmd.com

Transfer of Medical Records Authorization

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

TO: Blue Fish Pediatrics
23960 Katy Fwy, Suite 300
Katy, TX 77494
Fax: 713-467-0536

FROM: _____

FROM: Blue Fish Pediatrics
23960 Katy Fwy, Suite 300
Katy, TX 77494
Fax: 713-467-0536

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
 - 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 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