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 Sugar Land
17520 W Grand Parkway S, Ste 430
Sugar Land, TX 77479
Phone: 281-305-5970
Fax: 281-305-5971

FROM: _____
_____
_____
_____

□ FROM: Blue Fish Pediatrics Sugar Land
17520 W Grand Parkway S, Ste 430
Sugar Land, TX 77479
Phone: 281-305-5970
Fax: 281-305-5971

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

_____
Signature Date

_____
Witness Date