BLUE FISH
PEDIATRICS

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
920 Medical Plaza Dr., Suite 530
Shenandoah, TX 77380
Fax: 832-562-2007

FROM: ___________________________
____
____
____

☐ FROM: Blue Fish Pediatrics
920 Medical Plaza Dr., Suite 530
Shenandoah, TX 77380
Fax: 832-562-2007

TO: ___________________________
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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: ____
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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 Caleb Choe, M.D., and Claudia Hong. 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