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
27700 Northwest Fwy., Suite 440
Cypress, TX 77433
Fax:

FROM: _____
_____
_____
_____

□ FROM: Blue Fish Pediatrics
27700 Northwest Fwy., Suite 440
Cypress, TX 77433
Fax:

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 Note
  - □ 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