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
9530 Huffmeister Rd.
Houston, TX 77095
Fax: 832-427-1680

FROM: _____
_____
_____
_____

□ FROM: Blue Fish Pediatrics
9530 Huffmeister Rd
Houston, TX 77095
Fax: 832-427-1680

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 Theodora Mucher, M.D.,Annalisa Meadows, M.D., Dao-Albert Ho, M.D. and Dr. Kevin Doan, M.D.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