

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
9200 Pinecroft, Suite 465
Shenandoah, TX 77380
Fax: 832-562-2007

FROM: Doctor: _____
Phone: _____
Fax: _____
Address: _____

FROM: Blue Fish Pediatrics
9200 Pinecroft, Suite 465
Shenandoah, TX 77380
Fax: 832-562-2007

TO: Doctor: _____
Phone: _____
Fax: _____
Address: _____

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
 - 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 Claudia Hong, M.D., Amanda Chan, M.D., Neha Manikonda, M.D., and Katherine Bastie, 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