

BLUE FISH PEDIATRICS

PETER Y. JUNG M.D., F.A.A.P. • WILLIAM C. PIELOP M.D., F.A.A.P.
SECILY W. TORN, M.D., F.A.A.P. • AMANDA W. BRACK, M.D., F.A.A.P. • JILL EDDINGS, M.D., F.A.A.P.

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
915 Gessner, Suite 760
Houston, TX 77024
Phone: 713-467-1741
Fax: 713-467-0536

FROM: _____

FROM: Blue Fish Pediatrics
915 Gessner, Suite 760
Houston, TX 77024
Phone: 713-467-1741
Fax: 713-467-0536

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
 - 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 Peter Jung, M.D., William C. Pielop, M.D., and Secily Torn, M.D., Amanda W. Brack, M.D., and Jill M. Eddings, 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