

## 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  
9530 Huffmeister Road  
Houston, TX 77095  
Fax: 832-427-1680

FROM: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FROM: Blue Fish Pediatrics  
9530 Huffmeister Road  
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
  - 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 Jill Eddings, M.D and Suyearn Yu, 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