

BLUE FISH

P E D I A T R I C S

www.bluefishmd.com

Transfer of Medical Records Authorization – Dr. R. Adrian Clarke M.D.

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: TCPA Katy
705 S. Fry Rd. Suite 120
Katy, TX 77450
(P) 281-398-5376
(F) 832-825-8880

Please Include:

- Epic Medical Record Summary Letter and/or Epic “Snapshot” Summary
- Shot Record (Paper and Electronic)
- Growth Charts
- At least the last three (3) physician encounters
Please also include at least one well check encounter if one has been performed
- Developmental screen results
- 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 R. Adrian Clarke, 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