



Sunshine Pediatrics
 724 Arden Lane, Suite 100
 Rock Hill, SC 29732
 803-980-PEDS (7337)
 Fax: 803-980-BABY (2229)

**REQUEST FOR TRANSFER OR
 RELEASE OF HEALTH
 RELATED INFORMATION**

I hereby authorize and request that, for the child(ren) listed below, the following medical records be released (choose all that apply) from (choose where):

<input type="checkbox"/> All Records	<input type="checkbox"/> SC Certificate of Immunization	<input type="checkbox"/> Complete Vaccine Record (non-certified)
<input type="checkbox"/> _____ Results	<input type="checkbox"/> Physician Notes	<input type="checkbox"/> Payment History/Account Information
<input type="checkbox"/> Include old records from previous primary care physician(s)		<input type="checkbox"/> Other: _____

From:

Sunshine Pediatrics

From another facility: Name: _____
 Location/Ph#: _____

for the following dates: from _____ to _____ for the purpose of: transfer personal copy release

The information is to be released to the following person or facility (choose):

<input type="checkbox"/> Sunshine Pediatrics , 724 Arden Lane, Suite 100, Rock Hill, SC 29732, Fax 803-980-2229
<input type="checkbox"/> Transfer or Release information to:
Facility: _____ (addressee)
Address: _____ City/St/Zip _____
Phone: () _____ Fax: () _____
Attention: _____ Email _____
<input type="checkbox"/> Personal Copy to be released to: (Full name(s)) _____ (ID may be required)

The information is to be (choose): (Charges may apply)

<input type="checkbox"/> Mailed to the current home address	<input type="checkbox"/> Mailed to the above address	<input type="checkbox"/> Emailed (we cannot guarantee security)
<input type="checkbox"/> Faxed to the above number	<input type="checkbox"/> Picked up in person	<input type="checkbox"/> Discussed with above named party

Child(ren)'s Name(s):	Date(s) of Birth:	Sex:
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F

I understand that there may be an associated charge for providing these records.

Parent/Legal Guardian Printed Name: _____ Signature: _____ Date: _____

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**This authorization expires in 90 days from the above date.

If faxed, this fax transmission contains information which is confidential and/or privileged. This information is intended for use only by the addressee indicated above. If you are not the intended recipient, please be advised that any disclosure, copying, distribution, or use of the contents of this information is strictly prohibited, and that any misdirected or improperly received information must be returned to this office immediately. Your cooperation in phoning us about an erroneous receipt is requested. Thank you.