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):

- ☐ All Records
- ☐ _____Results
- ☐ Include old records from previous primary care physician(s)
- ☐ SC Certificate of Immunization
- ☐ Physician Notes
- ☐ Complete Vaccine Record (non-certified)
- ☐ Payment History/Account Information
- ☐ 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):

- ☐ **Sunshine Pediatrics**, 724 Arden Lane, Suite 100, Rock Hill, SC 29732, Fax 803-980-2229
- ☐ Transfer or Release information to:
  Facility: _____ (addressee)
  Address: _____ City/St/Zip
  _____
  Phone: ( ) _____Fax: ( ) _____
  Attention:_____Email_____
- ☐ Personal Copy to be released to: (Full name(s)) _____ (ID may be required)

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

- ☐ Mailed to the current home address
- ☐ Mailed to the above address
- ☐ Emailed (we cannot guarantee security)
- ☐ Faxed to the above number
- ☐ Picked up in person
- ☐ Discussed with above named party

Child(ren)'s Name(s):	**Date(s) of Birth:**	**Sex:**
		☐ M ☐ F
		☐ M ☐ F
		☐ M ☐ F
		☐ M ☐ F

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

Parent/Legal Guardian Printed Name: Signature: Date:

_____ _____ _____**

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