

Synshine 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 Record	Results	□ Physician No	e of Immunization tes re physician(s)		Payment Hi	accine Record (no story/Account Inf	ormation
From:		Sunshine Pediatr From another fac Location/Ph#:	cility: Name:					
for	the following	ng dates: from	to	for the purpo	ose of:	□ transfer	□ personal copy	□ release
The in	formation	ı is to be <u>releas</u>	sed to the follo	wing person or	facili	ty (choose)):	
	Transfer of Facility Addre Phone Personal	or Release inforty: ess: Copy to be rele	rmation to:	Fax: ((Attn: City/St/Zip		
□ N	Sailed to the	e current home add above number	dress □ Ma	ailed to the above ac	ldress		led (we cannot gu	
Ch	ild(ren)'s	Name(s):		Date(s)	of B	irth:	□ M	: 1
I under	stand that t	here may be an a	associated charg	ge for providing the	ese re	cords.		
Parent/Legal Guardian Printed Name:			me: Sign	Signature:			Date:	
								**
		**T	This authorizatio	on expires in 90 da	vs fro	m the above	date	

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