ALWAYS SUNNY PEDIATRICS

14 Philadelphia Ave, Shillington, PA 19607
Telephone: 610-871-3856 FAX: 610-871-7889 Website: www.alwayssunnypediatrics.com

Request for Medical Records

The hospital where your child was born:_____

Last Dr./Clinic where your child was seen:_____

Inpatient Hospitalization(s) _____

Emergency Room(s)_____

Any other Doctors or Specialists who saw your child:_____

To support the ongoing care of this patient, please forward copies of the health records for:

Name _____ Birthdate _____ Social Security #_____

Include the following:

Medical records	Laboratory & x-ray reports	HIV testing and related information
Inpatient	Drug and alcohol information	Immunizations
Outpatient	Social work evaluations	Psychological & Educational eval/testing
Newborn (including NB screen)		Records from previous providers of care

Mail to: Always Sunny Pediatrics
14 Philadelphia Ave,
Shillington, PA 19607

or

Fax: 610-871-7889

- This information, which may include sensitive psychiatric/substance abuse/HIV/AIDS, and mental health information, is needed for the purpose of continuity of medical care.
- I understand this information is disclosed from records whose confidentiality is protected by State and Federal Privacy Regulations.
- I do not have to sign this authorization in order to receive health care benefits (treatment, payment, or enrollment. However, I understand that better health care can be provided by Always Sunny if they are able to obtain these records. I further understand that authorization is necessary to take part in any research study or to receive health care when the purpose is to create health care information for a third party
- Always Sunny Pediatrics will protect these records to the best of their ability.
- These records may be conveyed from the above sources to Always Sunny Pediatrics by fax or US Mail.
- I also understand that I may revoke this authorization (except to the extent that action has already been taken) at any time by written, dated communication to any agency involved.
- This authorization is effective for a period of one (1) year from the date of my signature or until the requested agency has complied with this request.
- The nature and purpose of this release have been explained to my understanding.
- I acknowledge that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

Signature of Patient/Parent/Guardian _____ Date _____

For office use: Sent / Faxed on _____ By _____

reviewed AS 8/24/24