Sunshine Pediatric Partners, PLLC
New Patient Request

Child's Name: _____ DOB: _____
Chronic Conditions: _____
Daily Medication: _____

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Parent/Responsible Party: _____ DOB: _____
Address: _____ City: _____ Zip: _____
Social Security Number: _____ Phone Number: _____

Second Parent/Responsible Party: _____ DOB: _____
Address: _____ City: _____ Zip: _____
Social Security Number: _____ Phone Number: _____

Primary Insurance Carrier Name: _____
Contract Number: _____ Group Number: _____
Subscriber: _____ Co-pay: $_____

Secondary Insurance Carrier Name: _____
Contract Number: _____ Group Number: _____
Subscriber: _____ Co-pay: $_____

Who can we thank for referring you to Sunshine Pediatrics?

_____

This form can be returned by mail, fax; 989-401-3012 or email; office@sunshinepediatricpartners.com
Once your child's records have been received you will be contacted to schedule their first appointment.
Your child MUST be accompanied by a legal parent or guardian at the first appointment.

Thank you for choosing Sunshine Pediatric Partners!

SUNSHINE PEDIATRIC PARTNERS, PLLC
4855 BERL DRIVE
SAGINAW, MI 48604
PHONE 989-793-1202 FAX 989-401-3012

AUTHORIZATION FORM FOR THE REQUEST OF PROTECTED HEALTH INFORMATION

I (parent or guardian) _____ Authorize _____
Phone: _____ _____
_____
(Previous Doctor's office)

to disclose a copy of specific health information described below regarding:

Name: _____ DOB: ____/____/_____

Please initial the appropriate line of the description of the specific health information to be used or disclosed:

_____ Basic medical information including patient history, diagnosis summary, height, weight, Immunization information and lab sheet.
_____ Immunization Record.
_____ Any and all protected health information from the following dates: _____
_____ Any and all protected health information **including** the following; HIV status, mental health, alcohol or drug treatment.

Name of recipient to receive the information:

Sunshine Pediatric Partners, PLLC
Attention: _____
4855 Berl Drive
Saginaw, MI 48604

I understand that:

I may inspect or copy the protected health information to be used of disclosed.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.

I may revoke this authorization in writing at any time, provided that I do so in writing by contacting the office at the above address, except to the extent that the information has already been used or disclosed in reliance on this authorization.

Unless revoked earlier or otherwise indicated, this authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I may refuse to sign this authorization; you will not condition treatment or payment on my providing this authorization.

I have reviewed and understand this authorization. I will be provided a signed copy of this authorization.

Please sign here Parent or Guardian: _____ Date: ____/____/_____

Relationship to patient: _____

Witness: _____ Date: ____/____/_____

This release expires one year from the date the authorization was signed.
March 1, 2021