



Sunshine Community Health Center

Authorization to Release Information to Any Other Person

Many of our patients allow friends or family members to call and request the result of tests, procedures and financial information. Under HIPAA requirements, SCHC may not release information to any person without the patient's prior consent. If you wish to have your **medical information, any diagnostic test results and/or financial information released, or medication picked up** by any other person you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Sunshine Community Health Center to release my medical records, medications and any information to the following individuals.

1. _____ Relationship to Patient: _____ Phone: _____
2. _____ Relationship to Patient: _____ Phone: _____
3. _____ Relationship to Patient: _____ Phone: _____
4. _____ Relationship to Patient: _____ Phone: _____
5. _____ Relationship to Patient: _____ Phone: _____

Expires on _____

Does Not Expire

Patient Name (PLEASE PRINT)

Date

Patient Signature

DOB

S:\Front

Witness signature (must be over 18 years of age AND not a beneficiary)