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)