SUNSHINE
COMMUNITY HEALTH CENTER

Talkeetna Clinic
Mile 4.4
Talkeetna Spur Rd.
(907) 733-2273
HC89 Box 8190
Talkeetna, AK 99676

Willow Clinic
24091
Long Lake Rd.
(907) 495-4100
PO Box 1049
Willow AK 99688

Monday – Friday
Fax: (907) 531-5161
www.sunshineclinic.org

Authorization For the Care of a Minor

I/we _____and _____(parent(s) and/or legal guardian(s) give permission for Sunshine Community Health Center(SCHC) and it's providers to provide any necessary health care to:

Patient Name _____ **Date of Birth** _____

This authorization expires on the patient's 18th birthday, unless revoked on_____

In the case of my absence, the following person(s) may seek treatment for my child should health care be required (*do not include parent's/guardians).*

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Consent For Use and Disclosure of Protected Health Information (PHI)
I hereby give my consent for SCHC to use and disclose PHI about the patient and they may (check all that apply):

	Call my home		Text me		Mail to my home		Email me	

SCHC may leave a voice mail or message in reference to:

	Appointment reminders		Insurance items		Calls pertaining to clinical care

Written Acknowledgement Form
I have read and understand the form and its content. I have had an opportunity to ask questions. I have read and received or been directed to an electronic source to read the SCHC Notice of Privacy Practices.

Signature		**Date**	
Print Name			

Signature **Date**
Print Name _____ _____