HC 89 Box 8190 ▪ Talkeetna ▪ AK 99676 Tel. (907) 733-2273 ▪ Fax (907) 733-1735 ▪ schc@sunshineclinic.org ▪ www.sunshineclinic.org

AUTHORIZATION FOR THE CARE OF A MINOR

To whom it may concern;

I give permission for Sunshine Community Health Center and its physicians to provide any necessary medical care to my minor child.

My Child's full name: ____

Date of Birth: ____

This authorization expires on my child's 18th birthday, unless revoked.

In the case of my absence, the following person or persons may seek treatment for my child should health care be required.

Name: ____ Relationship: ________________________

Name: ____ Relationship: ________________________

Name: ____ Relationship: ________________________

1. CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Sunshine Community Health Center to use and disclose protected health information about me and they may: [check all that apply]

☐ call my home ☐ mail to my home ☐ e-mail me e-mail address: ___________________________

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

☐ appointment reminders ☐ insurance items ☐ calls pertaining to clinical care

2. WRITTEN ACKNOWLEDGEMENT FORM

I have read and understand the previous forms and their content. I have had an opportunity to ask questions. I have read and received or been directed to an electronic source to read SCHC Privacy policies.

Signature: ___________________________________ Date Signed: ______________________

Print Name: __________________________________