SUNSHINE COMMUNITY HEALTH CENTER

Talkeetna Clinic	Willow Clinic	Wasilla Clinic
Mile 4.4	24091	950 E. Bogard Rd.
Talkeetna Spur Rd.	Long Lake Rd.	Suite #233
(907) 733-2273	(907) 495-4100	(907) 376-2273
Fax: (907) 531-5161	Fax: (907) 531-5161	Fax: (907) 531-5161

Release of Behavioral Health Information

We will not process any request if you do not provide a fax and telephone number CD/Disc are not accepted.

Patient Name: _____ **Date of Birth:** _____

Requesting Provider _____

☐ Send Immediately ☐ Hold in Chart

I authorize Sunshine Community Health Center to: ( ) share information ( ) receive information:

Name _____

Address _____

Phone _____ Fax _____

Date range of request: _____ to _____

To Be Released * *from* ***SCHC***

____ Office Visit progress notes
____ Letter(s) of Progress
____ Evaluations/Assessments
____ Urine Drug Screen results
____ Verbal Communication
____ Other: _____

To Be Requested * *from third parties*

____ Treatment Plans
____ Progress Notes
____ Academic Records
____ Letter(s) of Progress
____ Evaluations/Assessments
____ Urine Drug Screen results
____ Verbal Communication
____ Other: _____

I specifically authorize the release of information relating to…
( ) Substance Use (Alcohol/Drug Use treatment) ( ) HIV/AIDS related information

This information is to be released for the purpose of…
( ) Coordination of care with: ( ) health care providers ( ) family members ( ) judicial system
( ) Other: _____

1. I understand that this authorization will **expire 180 days** from the date this form is signed.
2. I understand that I may cancel this authorization at any time by notifying SCHC in writing, and it will be effective on the date notified, except for any action already taken according to this authorization.
3. I understand that information sent or received because of this authorization may no longer be within our control, may be subject to disclosure, and as a result may no longer be protected by Federal privacy regulations.
4. I understand that I need not sign this form to ensure treatment, payment, enrollment, or eligibility for benefits.
5. I understand that it may take up to 30 days for this request to be processed.

Patient Signature _____ **Phone #** _____

Other Signature _____ **Relationship** _____

Witness _____ **Date Signed** _____

To be completed by SCHC Staff Only…

Received By _____ **Date** _____

Sent By _____ **Date** _____