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 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:** _____

I authorize Sunshine Community Health Center to:

☐ Receive information from… ☐ Send information to…

Name _____
Address _____

Phone _____ **Fax** _____
Email _____

☐	**Medical Office Visit Documentation**	**Date Range** _____
☐	Labs	Date Range _____
☐	Imaging	Date Range _____
☐	Diagnostic/Consultation Reports	Date Range _____
☐	Medication History	Date Range _____
☐	**Ophthalmology Office Visit Documentation**	**Date Range** _____
☐	Spectacle Prescriptions	Date Range _____
☐	**Dental Office Visit Documentation**	**Date Range** _____
☐	Imaging	Date Range _____
☐	**Other:**	**Date Range** _____

Will you be continuing your care at SCHC? Yes ☐ No ☐

1. I understand that this authorization will **expire in one (1) year** 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** _____