Sunshine Community Health Center

HC89 Box 8190 ◆ Talkeetna, Alaska 99676 ◆ Mile 4.4 Talkeetna Spur Road ◆ Telephone: (907) 733-2273 ◆ Fax: (907) 733-1735
Willow Clinic: P.O. Box 1049 ◆ Willow, Alaska 99688 ◆ 24091 Long Lake Road ◆ Telephone: (907) 495-4100 ◆ Fax: (907) 495-4106

RELEASE OF INFORMATION

Patient Name: _____ **Birthdate:** _____

We will not process any request if you do not provide a fax and telephone number

I authorize Sunshine Community Health Center to:

☐ **Receive information from** **OR** ☐ **Send information to**

Name _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____ **Fax** _____

Email _____

Information requested to be released: **DATES:**

- ❑ History and Physical Exam _____
- ❑ Laboratory/Pathology Reports _____
- ❑ Dental/Medical Radiology Reports/Films _____
- ❑ Dental/ Medical Reports/Progress Notes _____
- ❑ Other: _____

Will you be continuing your care at Sunshine Community Health Center? ❑ Yes ❑ No

1. I understand that this authorization will **expire 90 days** from the date the form is signed.
2. I understand that I may cancel this authorization at any time by notifying Sunshine Community Health Center 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 as a result 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 in order 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: _____ **Current Phone Number** _____

Relationship to Patient: _____ **Date:** _____

Witness: _____ **Date:** _____

Received by: _____ Relationship to patient _____ Date _____

SENT ON: _____ Initials