Sunshine Family Care Clinic
G3169 Beecher Rd, Suite 100
Flint, MI 48532
Phone 810-620-0250 Fax 810-620-0255

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Full Name (Please Print) _____

Maiden Name/Alias: _____

Date of Birth: _____ Social Security Number: _____

THE HEALTH CARE INFORMATION THAT I AUTHORIZE TO BE RELEASED INCLUDE:

☐ ALL HEALTH CARE INFORMATION IN THE MEDICAL RECORD
☐ Health care information in the medical record related to the following treatment or condition: _____
☐ Health Care information in the medical record for the date (s): _____
☐ Other (e.g., x-rays, labs, bills), specify date (s): _____

INCLUDE the following information from the records released (Please Initial):

☐ Mental Health/Psychotherapy Notes ____ ☐ Drug/alcohol use _____ ☐ HIV/AIDS _____
☐ Sexually Transmitted infections _____ ☐ Other _____

This record is requested for the following reason:

☐ Transfer of Care to (Name of Provider): _____
☐ Going to Specialist ☐ Insurance Purposes ☐ Personal Interest ☐ Legal Purposes
☐ Other (specify) _____

** FOR MULTIPLE PROVIDERS/CLINICS, PLEASE COMPLETE A NEW FORM

I request and authorize:

Clinic/Provider _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

TO RELEASE MY RECORDS TO:
Sunshine Family Care Clinic
G3069 Beecher Road, Suite 100
Flint, MI 48532-3611
Phone: 810-620-0250 Fax: 810-620-0255

I understand that the medical record released pursuant to this authorization could contain information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious diseases, which are subject to federal and/or state restrictions on disclosure. If Sunshine Family Care is asking to use/disclose my information, I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statement and consent to the disclosure of the medical record for the purpose and extend stated above.

SIGNATURE: _____ **Date:** _____
Patient, Parent, or legally authorized individual

Relationship to the Patient: _____ Social Security Number: _____ Phone number: _____

Expiration: This authorization expires on this date or event: _____. I understand this authorization will expire 90 days from the date signed if no specific date is indicated. The authorization may be revoked by notifying Sunshine Family Care Clinic in writing at any time except to the extent action has been taken prior to revocation.