Sunshine Family Cares, Inc.
G3169 Beecher Rd, Suite 100
Flint, MI 48532
Phone 810-620-0250 Fax 810-620-0255

AUTHORIZATION TO RELEASE/OBTAIN/EXCHANGE OR PROTECTED HEALTH INFORMATION

Full Name (Please Print) _____

Maiden Name/Alias: _____

Date of Birth: _____ Phone Number: _____

THE HEALTH CARE INFORMATION THAT I AUTHORIZE TO BE RELEASED/OBTAIN/EXCHANGED INCLUDES:

- ☐ 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 the date (s): _____
- ☐ Case Management Information (functioning capabilities, services provided/planned, barriers/needs, etc.)

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

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

This record is requested for the following reason:

- ☐ Transfer of Care to (Name of Provider): _____
- ☐ Referral ☐ Coordination of Care ☐ Insurance Purposes ☐ Personal Interest (Emergency Contact) ☐ Legal
- ☐ Other (specify) _____

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

I request and authorize:

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

TO: RELEASE/OBTAIN/EXCHANGE MY RECORDS TO:
Sunshine Family Cares, Inc
G3169 Beecher Road, Suite 100
Flint, MI 48532-3611
Phone: 810-620-0250 Fax: 810-620-0255

I understand that the medical record released under this authorization could contain information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood-borne infectious diseases, subject to federal and/or state restrictions on disclosure. If Sunshine Family Cares, Inc. is asking to release/obtain/exchange 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 now affirm that I have read and fully understand the above statement and consent to the medical record release/obtain/exchange for the purpose and extent stated above.

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 Cares, Inc. in writing at any time except to the extent of action taken before revocation.

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

Relationship to the Patient: _____ Phone number: _____