Please e-mail (password protected) to sunshinepeds@hotmail.com
fax to (520) 423-8398 or send by mail

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

(Please print)

PATIENT NAME: (Last) ________________ (First) ________________ (MI) ___
Patient address: ____________________________________City: ________________________
State: _______________ Zip code: __________
DATE OF BIRTH: _______________

IDENTIFICATION OF PROVIDER FROM WHOM RECORDS ARE BEING REQUESTED

(Please print)

PROVIDER'S NAME: _______________Phone: _______________ Fax: ___________________
Organization, Facility, or Affiliation (if different from above): _____________________________
Provider address: ____________________________ City: ________________
State: _______________ Zip code: __________

REQUEST FOR RELEASE (Patient signature required)

By evidence of signature below, the above named patient has requested medical records as specified below be released to **Sunshine Child and Adolescent Care**, for continuity of care. The patient expressly releases this information to Sunshine Child and Adolescent Care.

These records include, but are not limited to: personal patient information, medical histories, examination records, immunizations records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, and other related materials.
***Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

______________________________	___________________________
Patient or Legal Representative Signature (Required)	**Date**
______________________________	___________________________
If Signed by Legal Representative, Relationship to the patient	**Signature of witness**

This authorization will expire a year from today

ACKNOWLEDGEMENT OF PROHIBITION ON REDISCLOSURE

Sunshine Child and Adolescent Care acknowledge that this information is being disclosed from records whose confidentiality is protected by law. State and federal laws prohibit us from making any further disclosure of such information without the consent of the person whom such information pertains, or as otherwise permitted by such laws.

ADMINISTRATIVE INSTRUCTIONS

Sunshine Child and Adolescent Care, requests the above records are fax forwarded to:

Sunshine Child and Adolescent Care, INC.
1515 E. Florence Blvd. Suite 103
Casa Grande, AZ 85222
Phone: (520) 423-8282

Please attach a copy of this document to the records being forwarded.