SUNSHINE THERAPIES
SKILLS TODAY. BRIGHTER TOMORROWS.

Authorization to Exchange Health Information

Complete both pages, list each practitioner you authorize, select the information that may be shared, and sign. This form allows Sunshine Therapies and the practitioners you name to communicate about your care.

1 Client information

Full name: _____

Date of birth: _____ Phone: _____

2 Practitioners authorized to exchange information

I authorize Sunshine Therapies and its staff involved in my care to disclose the information selected below to, and receive it from, the following practitioners or practices. This includes verbal conversations and written or electronic records. Only the practitioners or practices named here are authorized by this form.

1. Practitioner or practice: _____

   Specialty: _____ Phone or secure contact: _____

2. Practitioner or practice: _____

   Specialty: _____ Phone or secure contact: _____

3. Practitioner or practice: _____

   Specialty: _____ Phone or secure contact: _____

For more practitioners, complete another copy of this form. Do not add names after signing.

3 Information that may be shared

Check each category you authorize. Only selected information may be exchanged.

- ☐ Health history and diagnoses relevant to my care
- ☐ Evaluations, assessments, and test results relevant to my care
- ☐ Treatment plans, goals, recommendations, and referrals
- ☐ Progress summaries and visit notes, excluding psychotherapy notes
- ☐ Medications and allergies relevant to my care
- ☐ Other specific information: _____

Record dates covered: From _____ to _____

Limits or information to exclude: _____

_____

This form excludes separately maintained psychotherapy notes and substance use disorder records protected by 42 CFR Part 2. Information requiring additional consent under applicable law may be shared only after that consent is obtained. Use a separate authorization when required.

Authorization to Exchange Health Information continued

Client full name: _____ Date of birth: _____

4 Purpose

The purpose is to coordinate my care, discuss my needs and progress, and support treatment planning among Sunshine Therapies and the practitioners or practices listed on page 1.

Other purpose, if any: _____

5 Expiration

This authorization begins on the date signed and expires on the following date or event related to my care. Complete one option before signing.

☐ Expiration date: _____

☐ Expiration event: _____

6 My rights and understanding

Signing is voluntary. Sunshine Therapies will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I sign this authorization.

I may withdraw this permission at any time by sending a signed written notice to Sunshine Therapies at the contact below. I should also notify each listed practitioner or practice that has received this authorization. Withdrawal takes effect for each recipient when that recipient receives my notice. It does not undo actions already taken in reliance on this authorization.

Sunshine Therapies contact for written withdrawal

Mailing address or email: _____

_____

Information disclosed under this authorization may be shared again by a recipient and may no longer be protected by the HIPAA Privacy Rule. Other applicable confidentiality laws may still protect it.

This authorization covers only the people, purposes, and information described in this form. It does not authorize marketing or sale of my information. I am entitled to a copy of the signed authorization.

7 Signature

I have read both pages and understand this authorization. I authorize the exchange of information as described above.

Client or authorized representative signature: _____

Date signed: _____ Printed name: _____

If signing for the client, relationship and legal authority to act for the client:

_____

Sunshine Therapies will provide the client or authorized representative with a copy of the completed, signed form.