Sandia Sunrise Therapy
LEARN.PLAY.GROW

MEDICAL RELEASE OF HEALTH INFORMATION

PATIENT INFORMATION

Child's Name: _____ Date of Birth: _____

Guardian's Name: _____

AUTHORIZED PERSONNEL INFORMATION

I authorize Sandia Sunrise Therapy to use, request, or disclose protected health information to/from:

Name: _____ Relation to Patient: _____

Phone Number: _____ Fax Number: _____

Email: _____

Unless otherwise specified below, this authorization will expire within one year from the request date.

Authorization Expiration Date (optional): _____

I authorize the release of protected health information for the above-mentioned patient to/from Sandia Sunrise Therapy to/from the above-noted person(s) or agency/agencies. I understand that this authorization is voluntary and that I may remove or modify this authorization at any time by providing a written notice. I understand that the information released may be subject to re-disclosure by some recipients and may no longer be protected by federal and state privacy rules related to health information. I understand that I have a right to a copy of this signed authorization.

Guardian's Signature: _____ Date: _____