Alumni Contact Authorization

Sunshine Coast Health Center
Powell River, BC

I (please print), _____, hereby agree to serve as an A.A. or N.A. contact (circle either or both) for other alumni of Sunshine Coast Health Center. I understand that Sunshine Coast Health Center will ***only provide my first name and phone number(s)*** to such persons; and that in any case, I will be contacted before any information is disclosed in order to verify my continued abstinence and involvement in A.A. and/or N.A. meetings.

I further understand that:

- I can revoke this consent at any time, except to the extent that action has been taken in reliance on it.
- Provision of services at Sunshine Coast Health Center may not be conditioned on my agreement to sign an authorization.
- Communication resulting from this authorization will reveal that I received services from Sunshine Coast Health Center.

Client's Signature Date

Address
Street/PO Box

City/Town Prov/State Postal/Zip

Telephone Numbers
Home: Cell: Work:

Date of birth (D/M/Y):

TO CANCEL: Place line through document, write "Revoked," sign and date and have client sign and date.