Referring Professional
Communication Authorization

I (please print), ________________________________ , hereby authorize Sunshine Coast Health Center to communicate with the following referral agent(s):

____

____

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 are not conditional on my agreement to sign this authorization.
- Communication resulting from this authorization will reveal that I received services from Sunshine Coast Health Center.

I authorize the following information to be communicated (check all that apply):

☐ Arrival of client in Vancouver
☐ Arrival of client at Center
☐ Client progress updates. If yes, frequency ________________________
☐ Early discharge date
☐ Scheduled discharge date
☐ Actual discharge date
☐ Other ____

Referring Professional Section

Preferred method of communication:
☐ Fax ☐ Phone ☐ Email. Phone #/Fax #/Email address: ______________________________________

If by phone, preferred day of week and time (indicate time zone): ______________________________________

Referring Professional Instructions: ____

____

Client Signature:____ Date: ____________________

Referring Professional Signature: _________________________________ Date: ____________________

PLEASE COMPLETE AND FAX THIS DOCUMENT 24 HOURS PRIOR TO ADMISSION. PLEASE FAX COMPLETED FORM TO 604.487.9012. ALL CORRESPONDENCE WILL REMAIN CONFIDENTIAL.