Sunshine Coast Health Centre
A Non 12-Step Program

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:** _____

THIS DOCUMENT MUST BE COMPLETED AND FAXED 24 HOURS PRIOR TO ADMISSION. PLEASE FAX COMPLETED FORM TO 1.888.875.0511 . ALL CORRESPONDENCE WILL REMAIN CONFIDENTIAL.