RELEASE OF INFORMATION / REFERRAL TO FORM - FOR OUTSIDE ORGANIZATIONS

Client Name:	County of Residence:
Client Address:	Client DOB:
Client Telephone #:	Referring Providers Name:
Referring Provider's Telephone:	

RELEASE OF INFORMATION

1. This authorization is for the use or disclosure of medical, mental health, case management, or service-related records between _____and **Sunburst Projects**, which may include their sub-contractors. I, the above-named client, hereby authorize by my signature the following organization to furnish any and all medical and health-related records and information pertaining to medical history, mental or physical condition, services rendered, case management notes and/or information associated with services rendered
2. This authorization for the release of records shall become effective as of the above date, and shall remain in effect for three years.
3. Agencies above and their sub-contractors may request information as it becomes available and at different intervals throughout the year.
4. Agencies above and their sub-contractors may use the client records exclusively for the purpose of assessment for the delivery and qualification for services, referral, and consultation with the agencies listed above including the use of mutual assist organizations, and other that may provide care to me on my behalf.
5. I have a right to request and receive a copy of this release.
6. I may cancel this agreement at any time by written notification to the agency listed above (Agency initiating Release of Information) and mailed USPS certified mail. The above agency who initiated the Release of Information will be responsible for notifying the other agencies above within two (2) business days from the receipt of the certified mail (3 days including delivery day).
7. Mandatory Reporting/Confidentiality Policy: You must give written consent before any information is released about you or your child. State and Federal law states the following exceptions to the confidentiality policy: (1) when a child has been physically or sexually abused or neglected; (2) when a person commits a crime against another person; (3) when a court orders disclosure of information; (4) when an individual poses an imminent threat to him/herself or another; (5) when mandated by State law, communicable disease(s).

I understand what I am signing, and have had any questions concerning this matter answered to my satisfaction.

Client/Legal Guardian Signature:	Today's Date:
Witness:	Today's Date:

REFERRAL

Current Medications (if known):	Last CD4 Count:	Date:
	Last Viral Load:	Date:

REASON FOR REFERRAL/SERVICES REQUESTED:

Please provide a copy of the client's most recent laboratory report when faxing this ROI/referral form

Signature of Referring Provider:	Date of Referral:

Please return this form to Sunburst Projects by faxing: 916-440-1208