Sunrise Psychiatry, LLC
721 Long Point Road
Suite 408B
Mt. Pleasant, SC 29464
Phone: 843-800-5070 *Fax*: 843-800-5074
Sunrisepsychiatry.com

AUTHORIZATION FOR COMMUNICATION

I, hereby authorize a representative from Sunrise Psychiatry, LLC to communicate directly with the following person(s) regarding treatment/appointments for _____ (Patient Name).

This is for the purpose of coordinating appointments, appointment reminders, messages and medication related issues. Authorization for Release of Medical Records requires a separate form.

Appts Only	Treatment	Name	Relationship	Phone #/Email
☐	☐	_____	_____	_____
☐	☐	_____	_____	_____
☐	☐	_____	_____	_____

I, hereby authorize a representative from Sunrise Psychiatry to call, leave a voicemail or send a message to via:

☐ Home ☐ Cell ☐ Email

I understand that this authorization shall remain in effect for duration of my treatment with Sunrise Psychiatry, LLC of information related to services provided to me.

I understand that all information shared by this authorization will be held confidentially and used only for the purpose stated above. I also understand that I must authorize in writing any other information to be released or any other person or agency to receive information.

_____ Date:_____
Signature of Patient:

_____ Date:_____
Signature of Guardian/authorized Representative (if a minor)

_____ Date:_____
Witness

This form shall remain valid until the patient withdraws authorization in writing.