



# Camp Sunshine



To find out about Camp Sunshine programs, please complete the following to be included on the mailing list:

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent (s)/Guardian(s): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (work): \_\_\_\_\_ (cell): \_\_\_\_\_

E-mail: \_\_\_\_\_

Date Diagnosed: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Primary Hospital: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Sibling's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sibling's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sibling's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sibling's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Authorization for Exchange of Information

I hereby authorize  
**Camp Sunshine Professional Staff**  
to:

\_\_\_\_\_ **OBTAIN INFORMATION FROM** \_\_\_\_\_ **PROVIDE INFORMATION TO**

Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

### AND/OR INDIVIDUAL

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Release of information, both written and verbal is requested explicitly for the purposes of the enhancement of the child's psychosocial intervention and continuity of care and will not be released to any third party.

RESTRICTIONS \_\_\_\_\_

This release of information may be revoked at any time by the persons signed below. All revocations must be in writing and signed.

DATE: \_\_\_\_\_ Signature of the Parent: \_\_\_\_\_

DATE: \_\_\_\_\_ Signature of Witness \_\_\_\_\_

Return to Camp Sunshine Staff or mail to:  
Camp Sunshine 1850 Clairmont Road Decatur, GA 30033  
Fax: 404-325-7929 Phone: 404-325-7979