SILVER OAKS
Behavioral Hospital

AUTHORIZATION TO DISCLOSE / OBTAIN INFORMATION FOR RELEASE OF MEDICAL RECORDS

1. I authorize _____ to: ☒ Disclose ☐ Obtain ☐ Disclose and Obtain
   Hospital / Agency / Individual

2. ☐ Discharge Summary ☐ Discharge Staffing ☐ Psychiatric Evaluation ☐ Social History
   ☐ History and Physical ☐ Treatment / HAB Plans ☐ Physicians Orders ☐ Progress Notes
   ☐ Behavioral Plans ☐ Consultations ☐ Lab/ X-Ray ☐ Photos
   ☐ Record Abstract ☐ Patient Review ☐ Medication Administration Records
   ☐ Assessments: _____ (*specify type*) ☒ Other: **ALL INFORMATION AS LISTED IN THE ENCLOSED SUBPOENA, LETTER OR ADDENDUM**

   Concerning the care of the below named person from Date or (Range of Dates): **AS SPECIFIED IN THE ENCLOSED REQUEST**

3. About (Name): _____ Social Security Number: _____
   Date of Birth: _____ Alias: _____

4. For purposes of: ☐ Personal Use ☐ Continuity of Care ☐ Placement Transfer ☐ Financial / Benefits
   ☒ Attorney ☐ State Law / Court ☐ Death ☐ Other: _____

5. Information may be disclosed / obtained: Mail, In-Person, Phone, E-Mail or by Fax (For Urgent/Emergency Needs).

   Restrictions if any: _____

6. ☒ Disclose to: (Name, Address, City, State, Zip, Phone, Fax or E-Mail)

   RECORDS DEPOSITION SERVICE, INC **P: 248.357.3330**
   PO BOX 5054 **F: 248.357.3337**
   E: REQUESTS@RECDEP.COM
   SOUTHFIELD, MI 48086-5054

   Relationship **AGENT FOR ATTORNEY**

   ☐ Obtain from:
   Silver Oaks Behavioral Hospital
   1404 Pawlak Parkway
   New Lenox, IL 60451

7. This authorization is valid one year from: _____

8. I understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider / plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA regulations.

9. I understand that I may revoke this authorization; however, the revocation must be in writing and must be sent/given to the facility record's department. I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

10. Refusal to sign this form will result in the following consequences: INFORMATION WILL NOT BE DISCLOSED / OBTAINED.

11. It is my full understanding that the records and communications to be disclosed WILL include sensitive information such as evaluation, rehabilitation/treatment information for mental health, developmental disabilities, alcohol or substance use/abuse or HIV/AIDs unless specifically checked below for **EXCLUSION**.
    ☐ Mental Health ☐ Developmental Disabilities ☐ Alcohol / Substance Abuse
    ☐ HIV/AIDs ☐ Other: _____

12. _____ _____ _____
    Signature of Individual (age 12 or older) Date Time

13. _____ _____ _____
    Signature of Guardian (Under 18 or Disabled) Date Time

14. _____ _____ _____
    Signature of Witness or (2nd parent/guardian, if co-custodial, may sign here) Date Time

15. _____ _____ _____
    Signature of staff person disclosing/obtaining information Date Time

Specific information about disclosures and dates shall be documented in the individual's clinical record or Disclosure Tracking System. A facsimile of this original shall have the same force and effect as the original.
The Standards for Privacy of Personally Identifiable Health Information, 45 CFR parts 160 and 164, states that information used or disclosed pursuant to this authorization may be subject to a re-disclosure by the recipient of the information. The federal confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug or alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 1. A general authorization for the release of medical or other information DOES NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52FR21809, June 9, 1987, 52 FR2 1997, November 2, 1987)
NOTE: Your refusal to sign an Authorization to Disclose / Obtain Information will not prevent treatment, payment or enrollment in a health plan or eligibility for benefits.