SunCloud Health

40 Skokie Boulevard, Suite 200, Northbrook, IL 60062 Phone 844-334-4178 Fax 847-996-2147

AUTHORIZATION TO RELEASE INFORMATION

A separate form is required for each individual/entity provider.

This form allows us to speak with the individual/entity provider listed below about your treatment.

PATIENT INFORMATION Patient Name____Birth date_________

Street Address____________________________________City, State, Zip:____________________________

Maiden/Other Name(s)____________________Phone (home/cell)_________________(work)______________

AUTHORIZATION AND PROVIDER *I hereby authorize SunCloud Health to release to, obtain from, use, disclose, receive and/or exchange, verbally and/or in writing, mental/behavioral health, medical information and/or records about the patient listed above with:*

Provider Name RECORDS DEPOSITION SERVICE, INC. Relation to Patient_______________Phone: 248-357-3330

Street Address PO BOX 5054 City, State, Zip SOUTHFIELD, MI 48086-5054 Fax: 248-357-3337

Email: REQUESTS@RECDEP.COM

PURPOSE The purpose for which information may be disclosed is to facilitate, support, inform and guide the patient's treatment at SunCloud Health and to provide continuity of care. Additional purposes are checked below:

☐ Future Treatment ☐ Employment reasons ☐ Insurance ☐ Personal Use ☐ Attorney/Client ☐ Other (specify)______________

DATES OF RECORDS AND/OR INFORMATION TO BE USED OR DISCLOSED ☐ Any/all previous treatment dates with provider listed above. OR

☐ Records or information from:________________________to________________________

[Beginning Date] [End Date]

DESCRIPTION OF MY INFORMATION TO BE USED AND DISCLOSED I understand that this authorization extends to all or any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug/substance use treatment, HIV/AIDS/STD test results or diagnoses, genetics, developmental disabilities, and protected health information. The information to be used, released or exchanged includes:

☐ Intake Evaluation(s)/Admission Summary

☐ Medication Records

☐ Medical History and Diagnoses

☐ Day Treatment Medical Records

☐ Treatment Summary

☐ Psychotherapy Notes

☐ Lab Reports

☐ Discharge Summary

☑ Other: SEE ATTACHED SUBPOENA OR LETTER REQUEST

☐ Neuropsychological/Psychological Evaluation Report

☐ IEP

SPECIALLY PROTECTED RECORDS (CHECK AND INITIAL)

________☐ Alcohol/Drug/Substance Use Treatment Records

________☐ Genetics

________☐ HIV/AIDS/STD

________☐ Developmental Disability

FOR RECORD COPY REQUESTS (CHECK ONE)

☐ Mail ☑ Fax ☐ Pick Up from SunCloud

EXPIRATION This authorization willexpire one year from the date signed below unless a specific expiration date is set forth here: __/__/____ **REVOCATION** I may revoke this authorization at any time in writing, signed, dated and witnessed and signed by a person who can identify me. The revocation will take effect when SunCloud Health receives it but I understand there is no effect on the uses/disclosures of my information that were made before SunCloud Health received my revocation or to the extent that SunCloud Health has already acted in reliance on my authorization. **REDISCLOSURE** Illinois law does not allow the re-disclosure of mental/behavioral health, genetics, developmental disabilities or HIV/AIDS/STD records or information by the recipient without permission of the person to whom it pertains, except as specifically permitted by law. Federal confidentiality law, 42 CFR Part 2, prohibits making any further disclosure of drug/alcohol/substance use information unless expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR. A general authorization for the use or release of medical or other information is insufficient for this purpose. **REFUSAL TO SIGN** I understand that I am not required to sign this authorization and the result would be that the information and records will not be disclosed. I understand that I am not required to sign this authorization in order to receive most services at SunCloud Health. However, I understand that if the ONLY reason I am seeing a SunCloud Health provider is to create health information for someone else's use (such as my employer), SunCloud Health may refuse to see me if I do not sign this authorization. For example, if I am here for pre-employment testing, then I must sign this authorization in order for SunCloud Health to perform the pre-employment test. **FEES** I may be charged a copying fee to complete this request. I may ask SunCloud Health for a fee estimate. **COPY** I understand that I will receive a copy of this completed form. **RIGHT TO INSPECT ©** I understand that I have a right to inspect and copy the records to be disclosed pursuant to this authorization.

CERTIFICATION By signing below, I authorize the release of, and consent to the use, disclosure, receipt and exchange, of the above-named patient's information and/or medical records described herein verbally or by written communication via fax, electronic means or copies/disc sent via U.S. Mail to or from the party indicated above, and understand the limits of confidentiality as a result of such transmission. The undersigned intends that copies or electronic versions of this document shall carry the same force and effect as the original.

The undersigned affirms that I am (check one): ☐ The patient, and the identification I have provided is true and correct OR ☐ The patient's authorized representative, and the identification and proof of authority that I have provided are true and correct.

____ ______________

Signature of Patient 12 years old and over Date Signed

____ ______________

Signature of Authorized Representative or Parent/Guardian Date Signed

______________________________ ______________________

Printed Name of Authorized Representative or Parent/Guardian Relationship to Patient (Authority to Sign for Patient)

____ ______________

Signature of Witness to Patient's Signature Date Signed

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