SKYWOOD RECOVERY
10499 N. 48th St.
Augusta, MI 49012
Phone: 269-282-7700
Fax: 269-216-4772

Patient Label

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Birth Date:_____

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody
☐ Academic ☐ Legal Investigation ☐ Other:_____

I **authorize the release of the following:**

☐ Comprehensive Assessment (Intake, Nursing, Psychosocial, Psychiatric and Education Assessments)
☐ History and Physical
☐ Discharge Summary
☐ Alcohol and Drug Abuse Treatment Records
☐ Discharge Instructions, Continuing Care Plan
☐ Physician's Orders
☐ Insurance/Payment
☐ Treatment Progress
☐ Psychological Evaluation
☐ Lab/Diagnostic Reports
☐ Progress Notes
☐ HIV Test Results and AIDS Treatment Records
☐ Other:_____ (include verbal only, when specified)

TO BE RELEASED BY: _____
Facility or Name

(_____)_____ (_____)_____ _____
Phone Fax Address - City - State - Zip - Email

TO BE RELEASED TO: _____
Facility or Name

(_____)_____ (_____)_____ _____
Phone Fax Address - City - State – Zip or Email

Relationship:

☐ Emergency Contact ☐ Other _____

☐ Reverse Request – Allows release to be reciprocal.

This authorization will expire on ____/____/20____. (If not indicated, authorization will expire one year from signature date)
You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. You have the right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.
This form must be completed in full before signing:

_____ _____ _____
Patient's signature Parent/Legal Guardian signature (if applicable) Relationship to Patient

_____ _____
Witness signature Date Signed

This authorization is intended to allow Skywood Recovery to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) or the STATE MENTAL HEALTH ACT is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. Skywood Recovery is not liable for such re-disclosures.

REVOKE this consent with signature/date below:

_____ _____
Patient's signature Date

_____ _____
Witness Signature Date