



SKYWAY BEHAVIORAL HEALTH MEDICAL RECORDS RELEASE REQUEST

CLIENT INFORMATION

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATES OF TREATMENT: \_\_\_\_\_ EMAIL: \_\_\_\_\_

SITE (CHECK ONE): Skokie – 4709 Golf Rd, FL 7 Downers Grove – 2001 Butterfield Rd, Ste 300

INDIVIDUAL / PROVIDER INFORMATION

I hereby request SKYWAY BEHAVIORAL HEALTH to release contents of the above-named client’s medical records to:

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

EMAIL: \_\_\_\_\_

RELATION TO CLIENT: Self Psychiatrist Therapist Case Manager
RD Primary Care Other: \_\_\_\_\_

I AM REQUESTING RECORDS BE SENT VIA: FAX ENCRYPTED EMAIL

FOR THE PURPOSE OF:

Personal Use Short/Long Term Disability Employment/FMLA
Continuity of Care Aftercare/Discharge Planning Other: \_\_\_\_\_

DISCLOSURE SHALL BE LIMITED TO THE FOLLOWING INFORMATION:

Assessments: Admission Assessment Psychiatric Evaluation History and Physical Nutrition Evaluation Spravato Assessment
Progress Notes: Therapy Psychiatry Nutrition
Labs Results/Vitals Treatment Plan Billing Information Discharge Summary Attendance Confirmation Dates of Admission/Discharge

EXPIRATION: This authorization is valid until \_\_\_\_\_. If no calendar date is entered, this authorization will expire after 180 days from the date of signature, except to the extent a longer term of validity is required by applicable law.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein described. I understand that I may revoke this consent at any time and that the above named organization authorized to receive this information has the right to inspect and copy the data disclosed. It is my full understanding that the records and communications to be disclosed contain evaluation and/or habilitation/treatment information for mental health, developmental disabilities and/or alcohol substance abuse and that my signature indicates my informed consent. HIV/AIDS information will not be released unless specifically requested. I understand that disclosure of health information to a party other than the one designated above is forbidden without any additional authorization on my part. I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) [P.L. 104191], 45 CFR pts. 160 and 164. My personally identifiable health information will only be used and/ or released in accordance with HIPAA and the Illinois Mental Health and Developmental Disabilities Confidentiality Act. This facility is released and discharged any liability and the undersigned will hold the facility harmless for complying with this Medical Records Release Request. The consent form shall be signed by the person entitled to give consent, and the signature shall be witnessed by a person who can attest to the identity of the person so entitled.

Client or Authorized Representative Signature Print Name & Relationship to Client Date

Witness Signature Print Name & Relationship to Client Date

Please send completed form to medicalrecords@skywaybh.com