SIERRA by the SEA
Where Waves of Change Begin

SUNRISE RANCH
Moving Recovery Forward

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Instructions: Fill in the appropriate information in each applicable section. Sign, date, and return the form. Incomplete forms will be returned to you unprocessed. A separate authorization must be completed for each request.

Patient Full Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

I hereby authorize: ☒Release Information to: ☒Exchange Information with:

NAME: Sierra by the Sea/ Sunrise Ranch	NAME: **RECORDS DEPOSITION SERVICE, INC.**
ADDRESS: 2800 Lafayette Avenue, Newport Beach, CA 92663	ADDRESS: **PO BOX 5054, SOUTHFIELD, MI 48086-5054**
PHONE: 949-673-6698 FAX: 949-675-4285	PHONE: **248.357.3330** FAX: **248.357.3337** **INFO@RECDEP.COM**

By signing below, I hereby authorize Sierra by the Sea/ Sunrise Ranch , or agent, to disclose information contained in the medical and financial record of the patient identified above, which includes information that may be stored in a paper and/or other electronic format. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex. Including communicable diseases or infections, sexually transmitted diseases, venereal diseases, tuberculosis, and hepatitis; demographic information; and treatment received at other healthcare facilities. Disclosure shall be limited to the following specific information contained in my records and/or obtained during the course of my diagnosis and treatment.

The following information is requested: (Checked items to be released)

☐Psychiatric Evaluation ☐Laboratory Reports ☐Financial Account Information
☐History & Physical ☐Immunization Records ☐Other (specify) _____
☐Practitioner Orders ☐ Medication Records _____
☐Practitioner Progress Notes ☐Treatment Plan _____
☐Discharge Summary ☐Discharge Instructions _____

The purpose or need for disclosure is:

☐To Transfer Patient Care ☐To Aid in Treatment ☐Application for Provider Coverage
☐For Follow Up Care ☐For Discharge Planning ☐Psychological Report
☐To Inform Family ☐To Update Medical Records ☐To Aid in Financial Account Activity
☐Referral Source ☐Employer ☐Other (specify) _____
☒Legal/Court System _____

I understand that the information in my health record may include information relating to sexually transmitted disease, immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse. State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drugs, or Substance Abuse Records ☐Yes ☐No Dates: _____
HIV Testing and Results ☐Yes ☐No Dates: _____
Mental Health Records ☐Yes ☐No Dates: _____

Disclosure Format: (Paper/US Mail or Fax is default if not marked): Specify "E-mail" or another electronic format: ALL

This authorization is valid only if received within 60 days of being signed. This authorization will expire at the time of disclosure of requested information or on _____(date cannot be more than 180 days after date signed below).

I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation.

I understand that information disclosed pursuant to tis authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws and regulations.

I understand that Sierra by the Sea will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I provide this authorization.

By signing below, I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from, the release of this information according to the request. I also expressly consent and authorize to be contacted by the phone number provided by any type of voice method and by auto-dialer technology for any permissible purpose.

Patient or Authorized Representative Signature	Date
Print Name and Relationship to Patient (if applicable)	Date

Notice to Recipient: This authorization provides for a release of information about an individual whose confidentiality is protected by federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (45 C.F.F 160-164) as well as 42 C.F.R. part 2 and 42 U.S.C. 290dd-2, and state confidentiality laws. No information disclosed from this authorization may be re-disclosed without the specific written consent of the individual about whom such information pertains.