HARMONY
Mental Health

Release of Information

Client name:		Client DOB:	

I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164, Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below. I understand that this authorization is voluntary and that I may revoke this authorization at any time by notifying Harmony Mental Health in writing, but if I do, it will not have any effect on any actions Harmony Mental Health took before it received the revocation.

I hereby authorize Harmony Mental Health or designated staff to (check all that apply):

☐Obtain records/information from:
☐ verbally:
☐ in writing:

☐ Release Records/information to:

Contact Name:			
Agency:			
Phone:		Fax:	

The information to be disclosed is:

☐Mental health status report
☐Progress notes / Treatment Plan
☐Chemical dependency evaluation
☐Case management notes
☐Family/ social history
☐Court and probation records
☐ Psychological / psychiatric / intellectual assessment
☐ Verification of program engagement / participation
☐ Summary of presenting problem(s), diagnostic findings, treatment, discharge and summaries
☐ Medical reports / health history
☐ School reports

☐ Other (specify): _____

For the purpose of: (please specify why information is being disclosed):

☐ Treatment planning ☐ Record completion

I understand that this authorization will expire on: _____ or within one year from the below date, whichever is earlier.

Signature of individual authorizing release _____ Date _____

Signature of witness (if required) _____ Date _____

Signature of parent/guardian (if required) _____ Date _____

HARMONY
Mental Health

Referral Form

CLIENT DEMOGRAPHICS

Referring Clinician
Client Name
Client Gender
Parent/Guardian
Phone Number

Clinician NPI
Client DOB
Client Age
Client Contact
Okay to leave message? ☐ yes ☐ no

Diagnosis
.

REFERRAL SOURCE INFORMATION

Skip if the referral source is the same on the attached release of information

Contact Name:			
Agency:			
Phone:		Fax:	

INSURANCE INFORMATION

Insurer
Insurance ID
Insurance Group

REFERRAL INFORMATION

(To be Completed by Referring Clinician)
Reason for Referral:
Psychosocial and Environmental Concerns:
Is the client currently seeing a Mental Health Provider? Who?

List All Known Medical Concerns/ Issues:
List All Medications:

History of Substance Abuse (describe substance abuse history including substance use, last use, age at first use, treatment history, and outcome of treatment)

Substance	Age of first use	Frequency /duration	Notes

Other:

AREAS OF NEED
(To be Completed by Referring Clinician)

SPECIALTIES/MODALITIES REQUESTED:

☐ EMDR
☐ Adaptive Internal Relational (AIR) Network
☐ Accelerated Resolution Therapy (ART)
☐ Dude therapy