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 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.

Only check if you DO NOT authorize Harmony Health or designated staff to:

☐ Obtain records/information from:

☐ Verbally:

☐ Release records/information to:

☐ In writing:

Contact Name: _____

Agency / Address: _____

Phone: _____

Fax:_____

The information to be disclosed is:

- Mental health status report
- Progress notes
- Treatment Plan
- Chemical dependency evaluation

- Case management notes
- Court and probation records
- Psychological Evaluations
- Psychological / psychiatric intellectual assessment
- Verification of program engagement / participation
- Diagnostic Assessment
- Summary of presenting problem(s), diagnostic findings, treatment, discharge and summaries
- Medical reports / health history
- Billing

For the purpose of:

- Evaluation report
- Treatment planning
- Record completion
- At the request of the individual
- Care coordination

I authorize all the above information to be disclosed for all their purposes.

☐ Yes – I authorize

☐ No – I DO NOT authorize, which I will explain in detail below.

X _____ _____

Signature of Patient/Client, Parent, Guardian or Personal Representative **Date**

If signed by a personal representative, relationship to patient: _____

Rev. 01/2025