HARMONY
Mental Health

Release of Information Authorization to Bill Third Party

Client name:		Client DOB:	

I (we) authorize Harmony Mental Health to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to all active insurances since 1/1/2025.

For the purpose of receiving payment directly to Harmony Mental Health, I understand that access to this information will be limited to determining insurance benefits and will be accessible to only to persons whose employment is to determine payments and/or insurance benefits. I understand that I may revoke this consent at any time by providing written notice and that after one year this consent expires. I have been informed what information will be given, its purpose, and who will receive it. I certify that I have read and agree to the conditions and have been offered a copy of this form.

Signature: _____

Date:_____

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