HARMONY UNITED PSYCHIATRIC CARE

Release for Medical Records / Client Information

I, _____ Date of Birth: _____
do hereby authorize Harmony United Psychiatric Care to release/obtain the following information pertaining to myself:

___ Ongoing comprehensive treatment coordination.
(including history and physical, progress notes, all labs/Imaging, etc.)

___ Presence in treatment. (including admission and discharge dates)

___ Diagnosis, brief progress and prognosis.

___ Psychological Assessment, Psychotherapy Notes.

___ Psychiatric Evaluations and management.

___ Substance Abuse evaluation and treatment.

___ Other: _____

This information may be released to/obtained from:

Physician/Company/ Hospital/ Person's Name : _____

Address : _____

Phone : _____

Fax : _____

This information is being requested for the following:

___ To coordinate with other healthcare providers.

___ To provide on-going treatment.

___ To enable judges, attorneys, probation/parole officers to support treatment goals
and/or to make informed legal decisions

___ To coordinate treatment efforts with my family/concerned persons.

___ To coordinate treatment and continuing care efforts with my employer.

___ To obtain insurance, employment or government benefits.

___ For emergency purposes, ONLY.

___ Other _____

If submitting patient records via mail to Harmony United Psychiatric Care, please send to:
104 E. Dixie Ave, Leesburg, FL 34748.
If submitting electronically, send to:
FAX: (352) 431-3173 or **EMAIL:** info@hupcfl.com

Release for Medical Records/Client Information Continued

NOTE: When substance abuse or dependence issues are relevant in client's medical records. I understand that the Release of Medical Records/Client Information has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR part 2) prohibit any further disclosure without specific written consent of the person it concerns. A general authorization for the release of medical or other information is not enough for this purpose.

This authorization shall remain in effect until:

___ Further notice of closing of case

___ Specific: Start date: _____ to Expiration date: _____

___ Specific _____ Event_____

I do voluntarily for the purpose(s) specified above, have the right to revoke this authorization, in writing, at any time. However, this revocation will not be effective to the extent that action has already been taken in compliance of my consent or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used, disclosed, or obtained pursuant to the authorization may be subjected to re-disclosure by the recipient to your information and no longer protected by the HIPPA privacy rule.

By signing this form, I authorize the use and disclosure of my health information in the manner described on the **"Release of Medical Records/ Client Information"** page. I have signed this form voluntarily in order to document my wishes regarding the use and disclosure of my health records.

_____ _____

Signature of the Client or Parent/Guardian **Date**

_____

Print Name

_____ _____

Signature of Witness **Date**

_____

Print Name

301 Skyline Drive, Suite 4, Lady Lake, FL 32159.
Phone: (352) 431-3940 | **Fax:** (352) 431-3173 | **www.hupcfl.com**