HARMONY UNITED PSYCHIATRIC CARE

Release of Medical Records / Client Information

I, _____ D.O.B: _____
do hereby authorize Harmony United Psychiatric Care to:☐ Release ☐ Obtain the following information pertaining to myself, my Client or my Child, _____, D.O.B:_____:

- ☐ 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 notes and prognosis.
- ☐ Psychological Assessment, Psychotherapy Notes.
- ☐ Psychiatric evaluations and management.
- ☐ Substance Abuse evaluation and treatment.
- ☐ Other: _____

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.
- ☐ Other _____

This information may be: ☐ Released to ☐ Obtained from: Physician/Company/ Hospital/ Person

Name :_____

Address: _____

Phone : _____

Fax :_____

If submitting patient records via mail to Harmony United Psychiatric Care, please send to:
301 Skyline Drive Suite 4
Lady Lake, FL 32159

If submitting electronically, send to:
FAX:(352) 431-3173 or EMAIL: info@hupcfl.com

NOTE: When substance abuse or dependency 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 a 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 HIPAA 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 Client/ Patient or Parent/ Legal Representative Date

_____

Print Name