HARMONY HEALTH
MEDICAL

Authorization for Release of Information

Patient Name _____

Date of Birth _____

Address _____

Phone Number _____

I hereby authorize Harmony Health Medical and its providers to share the information listed in this document with the person(s) or organization(s) specified below.

Health Information

The following information may be released to the parties listed below:

☐ Disclose my complete health record including but not limited to diagnoses, lab test results, treatment, and billing records.

OR

☐ History and physical exams

☐ Progress notes

☐ Mental Health records

☐ Lab reports

☐ Other: _____

Reason for Disclosure

Please write the reason why this information is being shared.

_____

HARMONY HEALTH
MEDICAL

Recipients

I give permission for the health information detailed in this document to be shared with the following person(s) or organization(s)

Name _____

Organization _____

Address _____

Phone _____ Fax _____

Duration

This authorization will expire exactly _____ days from the date signed.

Terms

1. I understand that I may revoke this authorization at any time by notifying Harmony Health Medical in writing.

2. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy rules.

3. I understand that failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatments or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits.

Signature

Patient _____ Date _____

Guardian _____ Date _____