AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

CLIENT NAME: _____ **DATE OF BIRTH:**_____

I hereby give my permission to **Harmony Harbor Counseling, LLC**, to release/request confidential mental health, medical and/or treatment information protected by HIPAA to/from a third party and/or identified person(s) named below. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Florida or federal law.

I authorize the release/request of information to the following:

To/From: _____
First and last name, phone, and address of person(s)
To/From: _____
First and last name, phone, and address of person(s)
To/From: _____
First and last name, phone, and address of person(s)

I authorize the type of information to be released/requested to include:

____Treatment Plans/Progress
____Health/Medical Records
____Psychological/Psychiatric Evaluations
____Evaluation/Assessment/Diagnoses
____Other (Specify): _____
____Progress Notes
____Letter(s)/Summaries of Progress
____Court Documents
____ Verbal Communication

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), such records may be protected from disclosure under the HIPAA Privacy Rule).*

____**(initial)** I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Harmony Harbor Counseling, LLC.

____**(initial)** I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Harmony Harbor Counseling, LLC will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

____**(initial)** I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or Harmony Harbor Counseling, LLC will not be held liable for information disclosed to another party per the client's request.

____**(initial)** I understand that Harmony Harbor Counseling, LLC will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

_____ Date: _____
Client Signature

FOR MINORS/DEPENDENT ADULTS:

_____ Date: _____
Printed Name of Parent or Legal Guardian/Relationship

_____ Date: _____
Signature of Parent or Legal Guardian