HARMONY
HEALTH GROUP

www.harmonyrecoverygroup.com

How to obtain copies of your medical records.

Please print the form on the next page, ensure all fields are complete, legible, and sign and date the form. Failure to properly complete the form may result in a delay in sending out the requested records.

Patient Identification. Print your complete legal name, any other names you might have used while a patient at a Harmony Health Group facility and your birthdate. It is important you include your address or telephone number in case we need to contact you with any questions or concerns with your release request.

Patient Identification. Print your complete legal name, any other names you might have used while a

Preferred Method of Release. Identify how you would like the information to be delivered by selecting either Mail, Fax, or Email.

Requestor Information. Who should the records be sent to? Per federal privacy regulations, if the requestor is not a healthcare provider, an individual name must be included. As applicable, it is also helpful to include the agency name (for example, Suzy Smith, Smith Law Firm). Please make sure to include contact and delivery information and how you want the information to be delivered (whether by mail, fax, or email).

Purpose of Release. Why is the information needed? Per federal privacy regulations we need to know why you are requesting copies of your records.

Information Requested. Select the information or type of records that you want to be disclosed.

HIV/AIDS Status. You have the right to choose not to disclose any information that includes your HIV/AIDS status. By selecting, "I do not want this included," our staff will do the best we can to review your medical record prior to release to ensure that any mention of HIV/AIDS status will not be disclosed. Please note that if HIV/AIDS status is mentioned anywhere in a record or note, including any lab results that would also include HIV/AIDS status, then that entire record or note will be withheld. This could impact insurance reimbursement, disability applications, or certain requestors if they do not receive the proper documentation. Our staff may release this information in the case of a medical emergency if it is vital for your care.

Psychotherapy Notes. A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.

Patient Signature. We cannot release your records without your signature.

Date. You must enter the date that you signed the release. All releases automatically expire one year from the date of your signature.

Fees. There may be a processing fee. Fees depend on the number of pages copied and are assessed in accordance with state and federal regulations.

Return the completed, signed form to the attention of Harmony Health's Medical Record Email:

medialrecords@harmonyhealthgroup.com
Fax: 772-247-4509

Release of Information/Authorization to Disclose Medical Records

Patient Name (print): _____ **Date of Birth**: _____

Other Name(s) Used in Treatment: _____

Phone Number: _____ **Email Address**: _____

Facility Name: _____ **Dates of Service**: _____

How would you like your record(s) sent? (Select One) ☐ Mail ☐ Email ☐ Fax

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I authorize Harmony Health Group and its affiliate facilities to communicate with and release my medical record(s) to:

Name (print): _____ **Attention**: _____

Address: _____ **Phone Number**: _____

_____ **Fax Number**: _____

Email Address: _____

Purpose of Release:

☐ Personal ☐ Insurance ☐ Legal ☐ Treatment/Continuing Care

☐ Verify Attendance ☐ Return to Work ☐ FMLA/Disability

☐ Other (specify) _____

Select record(s) or information to be released to party named above:

☐ Medical/Nursing Records ☐ Treatment Plan(s) ☐ Full Chart

☐ Laboratory Test Results ☐ Progress Notes ☐ Letter with Treatment Dates also include, if marked:

☐ Medication Records ☐ Discharge Summary/Notes ☐ Discharge Status

☐ Other (specify) _____ ☐ Recommendations/Plan

Information and records requested may include reference to my HIV/AIDS status. ☐ I do **not** want this included

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I understand that:

- My health information is protected by federal regulations (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and/or HIPAA, 45 CFR Parts 160 and 164) and state privacy laws. Disclosure is allowed only with my authorization except in limited circumstances described in Harmony Health Group's Notice of Privacy Practices.
- I have a right to inspect and receive a copy of my records that may be disclosed to others.
- This authorization will expire in one year from the date I sign it unless I request an earlier expiration. I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. (Harmony's Privacy Notice describes the procedure for revocation.)
- For disclosures other than for treatment, payment, and health care operations purposes, treatment may not be conditioned on my agreement to sign an authorization (unless I am receiving care solely to create protected health information for disclosure to a third party (42 CFR § 164.508(b)(4)(iii)).
- Communications resulting from this authorization will reveal that I received services at a Harmony Health Group facility.
- Federal confidentiality regulations (42 CFR Part 2) prohibit redisclosure of information from substance use disorder patient records.
- This authorization may be used by Harmony Health Group owned or -managed programs upon transfer of my care to them.

Patient Signature: _____ **Date**: _____

Parent/Guardian Signature (when required): _____ **Date**: _____

Return the completed, signed form to the attention of Harmony Health Group's Record Department

Email: medicalrecords@harmonyrecoverygroup.com
Mail: 1645 Palm Beach Lakes Blvd, Palm Beach, FL 33401
Fax: 772-247-4509

HARMONY HEALTH GROUP

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PSYCHOTHERAPY NOTES

PSYCHOTHERAPY NOTES DEFINITION: Notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. (45 CFR 164.501).

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all the information requested may invalidate this authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient: _____ **Date of Birth:** _____

Other Names: _____ **Telephone:** _____

Medical Record or Account # (if known): _____

I AUTHORIZE: _____
(Facility or Other Provider)

TO DISCLOSE TO: _____
(Persons/organizations authorized to ***receive*** the information)

at the following address: _____
(Street, City, State, and Zip Code)

the following information (check applicable boxes below):

☐ **All psychotherapy notes pertaining to me.**
☐ **Only the psychotherapy notes on the date(s) of treatment as specified:**
_____

PURPOSE: The purpose and limitations (if any) of the requested use or disclosure is:

☐ **At the request of the patient or personal representative; OR**
☐ **Other:** _____

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified: _____
(Insert Date, on which you want to revoke this authorization)

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following

address: _____.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

SIGNATURE: _____ DATE: _____

(Patient or Personal Representative)

PRINT NAME: _____ RELATIONSHIP TO PATIENT: _____

(Patient or Personal Representative)

Note: If the substance abuse treatment information is protected by federal confidentiality rules (42 C.F.R. part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:

The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.