HARMONIOUS MIND LLC

MENTAL HEALTH RECORDS AUTHORIZATION

1. PATIENT INFORMATION

Patient's Name: _____ DOB: _____
Street Address: _____
City, State, Zip: _____
Phone#: (home)_____(cell) _____

I authorize the use/disclosure of my mental health records and/or information as follows:

2. Party who has my Mental Health Records (who is sending my records)

❏ Harmonious Mind LLC
❏ Other: _____ Tel #: _____
Street Address: _____
City, State, Zip: _____

3. Party or Parties Who I want to Receive my Mental Health Records (who will get my information)

❏ Harmonious Mind LLC
❏ Other: _____ Tel #: _____
Street Address: _____
City, State, Zip: _____

4. Instructions (check one):

I understand that this record request can take up-to 30 days to process.
[❏ Mail at the above address] [❏ Fax to _____]
[❏ Email Encrypted File _____] [❏ I will pick up records.]

5. Purpose of Use/Disclosure of My Mental Health Records and/or Information

[❏ Medical follow-up] [❏ Employment/School reasons] [❏ Underwriting (insurance)]
[❏ Lawsuit] [❏ Patient request]

6. The Dates of Records and/or Information to be used or disclosed:

❏ Records or information from: _____ to _____
[Beginning Date] [End Date]

7. Description of My Mental Health Records and/or Information to be used and Disclosed

[❏ All Records] [❏ Medication History] [❏ Labs] [❏ Billing Records]
[❏ Testing Data/Results _____]
[❏ Other: _____]

8. Expiration

This authorization will expire one (1) year from the date I sign it. If I want it to expire on a different date, then that date is: _____

9. Canceling this Authorization:

I may cancel this authorization before it expires by writing a letter stating that I want to cancel it. I must sign the letter, date it and have a person who can identify me sign it as my witness. The letter must be delivered to harmonious Mind LLC at the address shown at the bottom of this page. The cancellation will take effect when Harmonious Mind LLC receives and processes the letter. I understand the letter will not have any effect on the uses/disclosures of my health information that were made before Harmonious Mind LLC processed my letter.

Specially Protected records (check and initial the following)

[❏_____ Alcohol/drug abuse treatment records] [❏_____ Genetics] [❏_____ HIV]

10. Re-disclosure of My Health Records and/or Information:

I understand that the person who receives my mental health information, alcohol and drug abuse records or HIV records may NOT disclose it to someone else without my permission, unless permitted by law.

11. Effect of Not Signing this Authorization:
I am not required to sign this authorization in order to receive most health care services at Harmonious Mind LLC. However, I understand that if the ONLY reason I am seeing a Harmonious Mind LLC provider is to create health information for someone else's use (such as my employer), Harmonious Mind LLC may refuse to see me if I do not sign this authorization. For example, if I am here for school or employment testing, then I must sign this authorization in order for Harmonious Mind LLC to perform the school or employment test.

12. Fees:
I may be charged a processing fee to complete this request, and I may ask Harmonious Mind LLC for a fee estimate.

13. Right to Inspect & Copy:
I understand that I have a right to inspect and receive a copy of the records to be disclosed pursuant to this authorization.

14. My authorization:

_____ _____
[Signature of Patient] [12 years old and over] [Date Signed]

_____ _____
[Signature of Legal Representative or Guardian] [Date Signed]

_____ _____
[Printed name of Representative or Guardian] [Relationship to Patient (authority to sign for patient)]

_____ _____
[Signature of Witness to Patient's signature] [Date Signed]

15. Return this completed form to the appropriate facility:
Harmonious Mind LLC
5189 W. Woodmill Dr.
Wilmington, DE 19808
Tel: (302) 633-6001 Fax: (302) 295-6289

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16. Provider Release Notification: (office use only)
❑ Dr. _____ has been notified of this release _____(initials/date)
❑ Dr. _____ has been notified of this release _____(initials/date)
❑ Admin ____ has notified all providers _____(initials/date)
❑ Dr. _____ has denied this release _____(initials/date)
Provide Copy of Signed Form to Patient