CONSENT TO RELEASE/OBTAIN INFORMATION
HARMONIOUS MIND, LLC

Psychiatric and Counseling Services
5189 West Woodmill Drive,
Woodmill Corp. Ctr., Suite. 30
Wilmington, DE 19808
Tel: 302-633-6001
Fax: 302-295-6289

I, _____, Date of Birth, _____
Name of Patient

authorize Harmonious Mind, LLC to: ___ RELEASE TO: ___ OBTAIN FROM:

the following agency, program, person:

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the following information:

_____

_____

PURPOSE OF RELEASING INFORMATION:

_____

PURPOSE OF OBTAINING INFORMATION:

_____

NOTE: Treatment is not conditioned by having to sign this consent. This information has been disclosed to the above named recipient from records protected under Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR parts 160 & 164. The information specified above will be disclosed pursuant to this authorization, and the recipient of the information may re-disclose the information, which may no longer be protected by the HIPAA privacy law. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. **To revoke this consent, the request must be done in writing to:** *Sanjay Wadhwa or your therapist at Woodmill Corporate Center, Suite 30, Wilmington, DE 19808.* If not previously revoked, this consent expires on date recorded below.

Executed on: _____ Expires on: _____

Signature of Client

Signature of Parent or Guardian or Authorized Representative