HARMONIOUS MIND, LLC

MENTAL HEALTH RECORDS AUTHORIZATION

(PLEASE FILL OUT COMPLETELY TO AVOID DELAY)

-Please be advised that Record Requests take UP TO 30 days to process-

Patient Information

Patient's Name: _____ DOB: _____ Phone #: _____
Street Address: _____
City, State, Zip: _____

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

Party who has my mental health records (who is sending my records)

[ ] Harmonious Mind, LLC

[ ] Other: _____ Phone #: _____ Fax #: _____
Street Address: _____
City, State, Zip: _____

Party who I want to receive my mental health records (who will get my records)

[ ] Harmonious Mind, LLC

[ ] Other: _____ Phone #: _____ Fax #: _____
Street Address: _____
City, State, Zip: _____

Instructions (check one)

[ ] Fax to: _____ **[ ]** Email to: _____ **[ ]** Mail to the above address **[ ]** I will pick up

Purpose of use/disclosure of my mental health records (check one)

[ ] Care Coordination **[ ]** Employment/School reasons **[ ]** Patient request **[ ]** Other: _____

The dates of records to be used/disclosed:

[ ] Records from _____ (beginning date) **to** _____ (end date)

Description of my mental health records to be used/disclosed (check one)

[ ] All records **[ ]** Medication History **[ ]** Lab results **[ ]** Billing records **[ ]** Other: _____

Expiration:

This authorization becomes effective immediately and shall expire on: _____.
If no date is given, this authorization expires 3 months after discharge from care at Harmonious Mind, LLC.

Revocation:

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Harmonious Mind, LLC at 5189 W. Woodmill Dr., Suite 30, Wilmington DE. 19808. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Re-disclosure of my mental health records:
I understand that the person who receives my mental health records may NOT disclose it to someone else without my permission, unless permitted by law.

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 or school), Harmonious Mind, LLC may refuse to see me if I do not sign this authorization.

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.

Specially protected records:

I understand that my health records may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis, hepatitis C, or genetics testing. If you do NOT wish this information to be released please initial:
Do NOT release: _____

Fees:

I understand that I may be charge a processing fee to complete this request, and I may ask Harmonious Mind, LLC for a fee estimate.

My authorization:

Signature of PATIENT: _____ Date: _____

Signature of GUARDIAN: _____ Date: _____

Printed name of GUARDIAN/relationship to patient: _____

Signature of WITNESS to patient/guardian signature: _____ Date: _____

Return this completed for to:
Harmonious Mind, LLC
5189 W. Woodmill Dr., Suite 30, Wilmington DE. 19808
Tel: 302-633-6001 – Fax: 302-295-6289

Provider release notification (for office use only):

Provider: _____ has APPROVED this release. _____ (initial) _____ (date)
Provider: _____ has APPROVED this release. _____ (initial) _____ (date)
Provider: _____ has DENIED this release. _____ (initial) _____ (date)
Provider: _____ has DENIED this release. _____ (initial) _____ (date)