harmonycares™
medical group

AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Name: _____

Date of Birth: _____

Address: _____

Phone: _____

AUTHORIZATION TO DISCLOSE

I hereby authorize HarmonyCares Medical Group, including its agents and employees (collectively 'HarmonyCares') to use or disclose the 'protected health information' of the Patient, covered under privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Rule"), as specified in this Authorization. I understand that "protected health information" includes records disclosed to the Patient's healthcare providers by healthcare providers and facilities who previously provided treatment to the Patient.

RECIPIENTS OF USE OR DISCLOSURE

The Patient's Health Information and Records may be used by or disclosed to (NAME AND ADDRESS OF RECIPIENT REQUIRED):

_____

_____

_____

If the recipient is an entity, then the Patient's Health Information and Records may also be used by or disclosed to that entity's agents and employees.

PURPOSE(S) OF THE USE OR DISCLOSURE

The purpose of the use or disclosure is for the following purpose (select any and all that apply): (a)
Continued Medical Care
(b) Legal Purposes
(c) Insurance Purposes
(d) Management of Medical Care
(e) Other_____

INFORMATION TO BE USED OR DISCLOSED

I authorize HarmonyCares to release the complete medical record, health history, physical or mental examination, condition, diagnosis, or prognosis, notes prescriptions, diagnostic test results, any reports, all images of any kind (x-rays, photographs, MRI, CT, etc.) and any and all other health information or records regarding the individual's health or treatment, including correspondence, phone messages and medical billing records (collectively the "Patient's Health Information and Records").

I understand that the medical record to be used or disclosed may include information and records protected under Federal Law (such as information regarding drug and alcohol abuse treatment information) and/or State Law (such as regarding mental health treatment, developmental disabilities, privileged communications, alcohol/drug abuse, communicable or infectious diseases, HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immunodeficiency Syndrome)). I specifically authorize HarmonyCares and its agents and employees to discuss, clarify, and provide explanation of the Patient's Health Information to the Recipient(s) described below.

I understand that if the person or entity that received the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosures of the medical record for the purposes and extent stated above.

EXPIRATION OR REVOCATION OF AUTHORIZATION

This Authorization will expire twelve (12) months after the date below or, if disclosure is for a court case, then this authorization will expire at the close of litigation, including all appeals for the following case: _____v._____, Case No. _____, currently pending in the following court_____.

I understand that I may revoke this Authorization by submitting a written revocation to HarmonyCares. However, such revocation will not be effective with respect to any use or disclosure made by HarmonyCares in reliance on this Authorization before HarmonyCares received my revocation.

I understand that this Authorization is voluntary and that HarmonyCares cannot condition the Patient's treatment, eligibility or benefits on whether or not I sign this Authorization.

I understand that the Patient's Health Information and Records used and disclosed by HarmonyCares pursuant to this Authorization may be subject to re-disclosure by the recipient, in which case they might no longer be protected under the HIPAA Privacy Rule. I hereby release HarmonyCares from any liability, damages and expenses arising in connection with the use or disclosure of the Patient's Health Information and Records pursuant to this authorization. A photocopy of this Authorization shall be valid and is to be accepted with the same effect as the original.

OR IF APPLICABLE:

Patient's Personal Representative Name (print)

Patient's Personal Representative Signature

Date:_____

Basis for authority to sign for Patient (Power of Attorney or Guardianship) and Relationship to Patient. **[Please attach Power of Attorney documentation or Order of Guardianship]** _____

Patient Name (print)

_____

Patient Signature

Date: _____