Neuro Harmony, LLC
1836 Victoria Lane, Charleston, IL 61920
Phone 217-508-7953 Fax 217-512-2288

RELEASE OF PROTECTED HEALTH INFORMATION

NEURO HARMONY, LLC at 1836 Victoria Lane, Charleston, IL 61920 is hereby authorized to release the following

Protected Health Information of: _____ _____
(Name of Patient) (Birthdate)

_____
(Address) (City, State, Zip Code)

Party to Receive Protected Health Information:

_____
(Name) (Address) (City, State, & Zip Code) (Phone)

The patient or authorized representative authorizes the use of protected health information to be released. Patient or authorized representative must initial the item, which needs additional protected health information disclosed.

___ Mental Health/Psychiatric ___ Psychotherapy Notes ___ Alcohol and/or Drug Related
___ Abuse ___ HIV/AIDS ___ Other Communicable Disease

The type of protected health information to be used or disclosed is as follows:

[ ] Medical History	[ ] Diagnosis and Prognosis	[ ] Social History
[ ] Psychiatric History	[ ] Psychological History	[ ] Treatment Plan
[ ] Educational History	[ ] Financial History	[ ] HIV Counseling History
[ ] Treatment Progress Notes	[ ] Substance Abuse History	[ ] Legal History
[ ] Employment History	[ ] Summary and Recommendations	[ ] Verify Presence
[ ] Drug Test Results	[ ] HIV Testing Results/History	[ ] Billing

[ ] Other (must be specific information): _____

Method of release: [ ] Photocopies [ ] Verbal [ ] FAX [ ] Written
For the purpose of: [ ] Continued Treatment [ ] Evidence of Care [ ] Legal [ ] Billing

The foregoing authorization was read, discussed, and signed in my presence. I am signing freely and with full knowledge and understanding. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that other healthcare provider records may be a part of my record and I can release them as authorized. I understand that any disclosure of information carries with it the potential for unauthorized disclosure if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by the Federal Health Information Privacy Regulations. The redisclosure of drug and alcohol abuse is generally prohibited with the confidentiality of alcohol and drug abuse patient record rules. I understand that I can contact these departments for questions about disclosures of my protected health information.

I further understand that a refusal to authorize the release of the above information will prevent the disclosure of the information without further authorization or when mandated by law. There is the right to revoke the authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides the insured with the right to contest a claim under my policy.

The date of authorization expiration will be one year (1 year) from date signed.

Signed _____ Date _____

Witness _____ Date _____