Harmony Community Clinic
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Authorization for Use and Disclosure of Health Information

Use this form to request records from another provider or to send your Harmony Community Clinic records to someone else.

Patient name (print) _____ Date of birth _____ Date _____

1. Direction of request (check one)

☐ Release FROM the provider below TO Harmony Community Clinic
☐ Release FROM Harmony Community Clinic TO the person or provider below

Name of provider, facility, or person _____ Phone _____ Fax _____

Address _____ Email _____

2. Information to be released

☐ Complete record ☐ Office / progress notes ☐ Laboratory results
☐ Imaging reports ☐ Medication list ☐ Immunization records
☐ Consultation reports ☐ Billing records ☐ Other: _____

Dates of service (from) _____ Dates of service (to) _____

3. Specially protected information

Federal and Florida law require specific permission for the information below. Initial each item you authorize to be released. If you do not initial an item, it will not be released.

HIV/AIDS testing, diagnosis, or treatment _____ Initials

Mental health or psychotherapy information _____ Initials

Alcohol or substance use disorder treatment records _____ Initials

Sexually transmitted infection testing or treatment _____ Initials

Genetic testing results _____ Initials

4. Purpose

☐ Continuity of care ☐ Personal use ☐ Insurance
☐ Legal ☐ Other: _____

5. Expiration

This authorization expires on this date or event: _____. If no date or event is written, it expires one (1) year from the date signed.

6. My rights

- I may revoke this authorization at any time by giving written notice to Harmony Community Clinic, except to the extent action has already been taken based on it.
- My treatment, payment, enrollment, or eligibility for benefits will not depend on whether I sign this authorization.
- Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy law. Substance use disorder records are protected from re-disclosure by 42 CFR Part 2.
- I may receive a copy of this signed authorization. Reasonable copying fees may apply as allowed by Florida law.

Signatures

By signing below, I confirm that I have read this form (or had it read to me) in a language I understand, that I had the opportunity to ask questions and all of my questions were answered, and that I agree to its terms voluntarily.

Patient name (print)	Patient signature	Date

Parent / guardian / legal representative (print, if applicable)	Relationship to patient	Representative signature	Date

Provider name and credentials	Provider signature	Date

Tell us about your visit

Your opinion helps other families find quality care. After your visit, scan this code with your phone camera to leave Harmony Community Clinic a review on Google.

Thank you for trusting us with your health.