Harmony Mental Health Services NW
1499 Tech Center Place, Suite 190,
Vancouver, WA 98660

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I, _____, authorize HARMONY MENTAL HEALTH SERVICES NW at the above address to:

Patient Name (Print) Physician Name (Print)

MD check all that apply

- ☐ Receive my medical history information from the following physicians:
  (name, address)_____
  (name, address)_____
- ☐ Receive my treatment records from the following therapist:
  Therapist (name, address)_____
- ☐ Release my treatment information to the health insurance company listed below, for billing purposes:
  Insurance provider (name, address)_____
- ☐ Receive information from all HARMONY MENTAL HEALTH SERVICES NW therapists:
  Therapist (name, address)_____
- ☐ Receive and Release my treatment information and medical history to/from:
  _____
  _____

This information is for the following purposes (any other use is prohibited): _____

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that any action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during the treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIS (AIDS) or related illnesses. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

–

_____ _____ _____
Patient Signature Patient Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date