CONSENT FOR RELEASE OF INFORMATION

I _____, DOB _____.

Authorize: Harmony Health/ Dr Yolandie McCoskey
3100 Dick Pond Road
Suite C-2
Myrtle Beach SC 29588
Office# 843.251.9500 Fax# 843-831-0021

To disclose to:

Clinic/Physician Address City Zip Phone

_____

_____

_____

[ ] Please email to : _____

[ ] Please fax to : _____

[ ] Other: _____

The following information:

[ ]All medical records including medical, psychiatric, and drug treatment. The purpose of this disclosure is for medical, psychiatric, and drug treatment.

[ ] Other: _____

Expiration:
This authorization expires 2 years after the below signed date.

Notice Prohibiting Redisclosure:
This information has been disclosed to you from records protected by Federal confidentiality rules (Title 42, Part 2, Code of Federal Regulations[42 C.F.R. Part 2]). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. This authorization may be revoked in writing at any time, and must be submitted to the releasing party. Written cancellation in the future will have no effect on any records that may have been released prior to the cancellation. I understand that Harmony Health cannot provision my treatment, payment, health plan enrollment, or eligibility for benefits on the provision of this authorization. I understand that a copy of this release is as valid as the original. I understand I may receive a signed copy of this form by request. I express consent to the release of information as designated above.

Signature of patient/guardian_____ Date_____