**Authorization to Release Confidential Information**

NAME OF PERSON: ___________________________________________________________

DOB: ___________________________

I authorize Harmonie House LLC to release the following information about the above-named person:
☐-All of my health information
☐-My health information related to the following treatment or condition
☐-My health information covering the following time periods __________ (date) to __________(date)
☐-Other

I authorize Harmonie House and its affiliates to receive or disclose my individually idnetifiabl health informatio to pysicians, hosptials, pharmacies, medical equipment suppliers, case management agencies, community services providers, socil services organizations, mental health services providers, insurance providers, and other sources or organizations involved in maintianing my independent living status or nursing home placement. Additionally I authoirze Harmonie House and its affiliates to receive from or disclose my individually identifiable health information to the following:

This information is to be released to (name and organization):

______________________________________________________________________________________

The information is to be released for each of the following purposes:

-To coordinate care______________________________________________________________________

I understand that this authorization will be valid only for a period of ONE year from the date of my signature. I understand that I may revoke this authorization at any time upon written request to Harmonie House LLC. I understand that if I revoke this authorization, it will not have any effect on actions taken by Harmonie House LLC in reliance on this Authorization prior to the date of revocation.

__________________________________________ ___________________

Signature (Parent of a minor/Guardian/Self) Date:

__________________________________________ ___________________

Relationship to Individual Date: