HIPAA Privacy and Release of Information Authorization

I, _____ hereby authorize **Harmony at Home Provider Services, LLC dba At Home Harmony** and its affiliates, its employees and agents (collectively "Practice"), to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that I have a right to revoke this authorization by providing written notice to the Practice. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Patient Name: (please print)		**DOB:**	
Signature of Patient / Guardian:			
Date Signed:			