HARMON
Psychotherapy
& Consulting

Release of Information

Client's name:

_____

I authorize Harmon Psychotherapy & Consulting to:

☐ Send ☐ Receive

The following information:

- ☐ Medical history and evaluations
- ☐ Mental health evaluations
- ☐ Developmental and/or social history
- ☐ Educational records
- ☐ Progress notes, and treatment or closing summary
- ☐ Other

List all providers/facilities you would like Harmon Psychotherapy to send/receive information to/from.

To/From: _____ Relationship to client: _____

Phone:

_____

Your relationship to client: (who is filling out this form)

- ☐ Self
- ☐ Parent/legal guardian
- ☐ Personal representative
- ☐ Other _____

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The above information will be used for the following purposes:

- ☐ Planning appropriate treatment or program
- ☐ Continuing appropriate treatment or program
- ☐ Determining eligibility for benefits or program
- ☐ Case review
- ☐ Updating files
- ☐ Other

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I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

_____ _____

Signature Date

_____ _____

Witness Signature (if client is unable to sign) Date

(801) 687.9509
760 N 530 E
Orem, UT 84097
www.harmonpsychotherapy.com
contact@harmonpsychotherapy.com

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Therapist Referral

Client's name:

_____

Therapist's name: Therapist's email:

_____ _____

Please describe the reasons you are referring your client to DBT skills classes:

_____
_____
_____
_____
_____
_____

For what mental health diagnoses is your client currently seeking treatment?

_____

Please check the skills module(s) your client is wishing to participate in:

- ☐ Emotion Regulation
- ☐ Distress Tolerance
- ☐ Mindfulness (mindfulness skills are folded into all three modules)
- ☐ Interpersonal Effectiveness

Has your client experienced any of the following in the past 6 months:

- ☐ Self-harm thoughts
- ☐ Self-harm behaviors
- ☐ Suicidal thoughts
- ☐ Suicidal behaviors
- ☐ Eating disordered behavior

Have any of the above resulted in hospitalization?

- ☐ Yes
- ☐ No

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If “yes,” for how long was your client hospitalized? _____

Would you like weekly emails letting you know the topic of the class and the homework?

☐ Yes ☐ No

Are you ok with us contacting you if we have concerns about your client?

☐ Yes ☐ No

Participation in DBT classes at Harmon Psychotherapy requires each participant to be engaging in weekly individual therapy. Is your client currently participating in weekly individual therapy with you?

☐ Yes ☐ No

The above information has been provided to the best of my knowledge.

_____ _____

Signature Date

_____

Title/Credentials