Nashville NeuroCare Therapy

2001 Mallory Lane, Suite 304
Franklin, TN 37067
Phone 615-465-4875
Fax 615-472-9479
www.nashvilleneurocare.com

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD
(Also known as Protected Health Information)

Patient Name _____ _____ Date of Birth _____
Address(Mailing)_____Phone_____
_____

I authorize the release of my protected health information:

To/From: W. Scott West, MD

To/From: _____
Phone _____ Fax _____
Information to be released _____
Purpose of disclosure _____

This form, when properly completed, permits the release of confidential information about a person receiving services. Any information to be released under this form shall be released in accordance with HIPAA. The records released through this authorization are protected by HIPAA. Further disclosure of this information to parties other than those designated on this form is prohibited without the written consent of the person to whom the information pertains.

1. I understand that information used or disclosed pursuant to this authorization carries with it the potential for an unauthorized re-disclosure which may not be protected by Federal Privacy regulations.
2. I understand that signing this Authorization is voluntary and refusing to will not jeopardize my right to obtain present or future treatment except where disclosure of the information is necessary for the treatment.
3. I understand that I may revoke this Authorization by doing so in writing at any time; except to the extent that action has already been taken in reliance upon it, and that the revocation does not affect any information that was released before the revocation. Even if I do not revoke this Authorization, the Authorization expires automatically one (1) year from the date of signature.

Signature _____ Date _____

Signature of Parent or Legal Guardian _____