neurocare Centers of America | Nashville Neurocare Therapy

Nashville Neurocare Therapy
Phone: (615) 465-4875
Fax: (615) 472-9479
www.nashvilleneurocare.com

COOL SPRINGS
2011 Mallory Lane, Ste 304
Franklin, TN 37067

GREEN HILLS
30 Burton Hills Blvd, Ste 360
Nashville, TN 37215

MURFREESBORO
1725 Medical Center Pkwy, Ste 215
Murfreesboro, TN 37219

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

Patient Name: _____ Date of Birth: ____________

Address (Mailing): _____

City: _____ State: _____ Zip Code: _____

Phone: _____

_____

I authorize the release of my protected health information:

To/From: Nashville Neurocare Therapy

To/From: _____

Phone: _____

Information to be released: Intake/Psych eval, Medical records, Diagnoses, Medications w/ doses and durations

Purpose of disclosure: TMS Evaluation

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 Guardian: _____