

Authorization for Release of Information

Date: _____ Patient Phone Number: _____

Patient Name: _____ DOB: ____/____/____ SSN: ____-____-____

Patient Address: _____

I hereby authorize the release of my protected health information

From/To: William Bryan Bell, M.D. / T. Kurt Moss, APRN-BC

From/To: _____

2001 Mallory Lane, Suite 303

Franklin, TN 37067

Phone: (615) 567-7881

FAX: (615) 567-3381

Phone: _____

FAX: _____

I hereby authorize the release of the following information: (check all that apply)

- Yes No HIV status and or related information including AIDS initial
- Yes No Substance Abuse/Dual Diagnosis (including alcohol/drug abuse) initial
- Yes No Medical History (Laboratory results, medications, treatment reports).
- Yes No Psychological test/psychiatric evaluation/neurological workup.
- Yes No Social history, including family, education, employment, arrest, and drug use information.
- Yes No Summary of previous mental health treatment.
- Yes No Periodic reports of treatment progress including attendance, participation and urine surveillance results.
- Yes No Other (specify)

I understand that this information will be used for other following specific purposes: (Check Yes or No)

- Yes NO To develop a diagnosis, treatment and rehabilitation plan.
- Yes NO To coordinate medical, psychological and social rehabilitative process.
- Yes NO To determine present and future eligibility for probation, parole, bail bond, pre-trial release or other diversion process within the criminal justice system.
- Yes NO To process insurance claims for services provided (diagnosis, number of visits, modalities, and expected length of treatment.)
- Yes NO Other (specify)

I understand that this information will not be disclosed to any other agency or individual without my written authorization, except as allowed by law. I also understand that my protected health information, which is disclosed with this release, may be subject to re-disclosure by the recipient and no longer protected by law. Dr. Bell is not responsible for any alterations made on its medical record copies, which have been released to any party. I understand that any release which has been made prior to my revocation and which was made on the basis of this authorization shall not constitute a breach of my Right of Confidentiality. I understand my records are protected under the federal regulation 42, CFR Part 2, HIPPA and TCA 33 and cannot be disclosed without my written consent unless otherwise provided for in these regulations.

- I understand that I have a right to a copy of this authorization after I sign it.
- I understand that Dr. Bell will not condition any provision of treatment on my signing this authorization.
- **This authorization automatically expires in one year and may be revoked at any time with my written statement.**

Signature of Client Date

Signature of Parent / Guardian Date

Signature of Witness Date

Please include a photo ID when
requesting an electronic
release of records