Authorization for Release of Information

2001 Mallory Lane, Suite 303 Franklin, TN 37067 Phone: (615) 567-7881 FAX: (615) 567-381 FAX: (615) 567-381 Support@bellpsychiatric.com I hereby authorize the release of the following information in Facsimile or Email form: My Full Psychiatric Medical Health Record I understand that this information will be used for other following specific purposes: For Continuity of Care I understand that this information will not be disclosed to any other agency or individual without my written authorization, except as allowed to low. I also understand that this information will not be disclosed to any other agency or individual without my written authorization, except as allowed to low. 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 low. Dr. Bell is not responsible for any alterations made on its medical record copies, which have been released to any party. I understand that my release which has been made prior to my revocation and which was made on the basis of this authorization lor constitute a breach of my Right of Confidentiality. I understand my records are protected where the federal regulations 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.	Date: _					
To: William Bryan Bell, M.D. 2001 Mallory Lane, Suite 303 Franklin, TN 37067 Phone: (615) 567-7881 Phone: (615) 567-7881 Phone: (615) 567-7881 FAX: (615) 567-3381 FAX: (615) 567-3381 Support@bellpsychiatric.com I hereby authorize the release of the following information in Facsimile or Email form: My Full Psychiatric Medical Health Record I understand that this information will be used for other following specific purposes: For Continuity of Care I understand that this information will not be disclosed to any other agency or individual without my written authorization, except as allowed to low. 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 low. D. Bell is not responsible for any alterations made on its medical record capies, which have been released to any provision and an its medical record capies, which have been released to any provision and that the protected when the basis of his authorization shall not constitute a breach of my Right of Confidentiality. I understand my records are protected under the federal regulations. • I understand that I have a right to a copy of this authorization after I sign it. • I understand that Thave a right to a copy of this authorization after I sign it. • I understand that D. 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.	Patient	Name:		_ DOB:/	_/	
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