Authorization for Release of Information

Date: _____

Patient Name: _____ DOB: ____/____/____

I hereby authorize the release of my protected health information

To: William Bryan Bell, M.D.
2001 Mallory Lane, Suite 303
Franklin, TN 37067
Phone: (615) 567-7881
FAX: (615) 567-3381
Support@bellpsychiatric.com

From: NeuroScience & TMS Treatment Centers Clinicians
7104 Peach Court, #103
Brentwood, TN 37027
Phone: 615-224-9800
FAX: 615-224-9840

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 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