



CONSENT TO RELEASE INFORMATION

Patient Name: _____ **Date of Birth:** _____
I, AUTHORIZE:

Organization/Physician	Location	Phone & Fax	PURPOSE Coordination
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

to DISCLOSE and RECEIVE information contained in my record TO and FROM,

CEREBRAL CARE CONSULTING
1906 Glen Echo Road. Nashville, TN 37215.
admin@cerebralcareconsulting.com
mobile: 615-619-6300 **fax: 615-619-6306**

The following information:

- All medical records, including medical, psychiatric, and drug treatment.
- The purpose of this disclosure is for medical, psychiatric, and drug treatment.

Expiration: This authorization expires 2 years after the date below or whenever Cerebral Care Consulting, LLC is no longer providing me with services.

Notice Prohibiting Redisclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (Title 42, Part 2, Code of Federal Regulations [42 C.F.R. Part 2]). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Printed Name of Patient: _____

Signature of Patient or Authorized Representative: _____

Date: _____

Printed Name of Patient or Authorized Representative: _____

Relationship to Patient (if applicable): _____

