THE NORTHSHORE GROUP
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KNOXVILLE, TN 37919-4054
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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form authorizes the release of protected health information to a designated person or agency.

- Name of patient: ______________________________ DOB: ___ /___ /___ SSN: _____-____-_____
- I authorize ____to release the following information about

  [myself / my minor child / my legal charge] (circle one):

  ____ Mental health care information relating to the following treatment or condition:

  ____

  ____ Mental health care information for the following date(s): ________________________________

  ____ All mental health care information

  ____ Other ____

- This information should only be released to:

  Name: ____ Phone / Fax _________________

  Address: ____

- I am requesting the release of this information for the following reason(s): ("At my request" is all that is required if you do not desire to state a specific purpose)

  ____

- This authorization shall remain in effect until ________________________ (fill in a date or an event).
- I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address above. I also understand that my revocation will not be effective to the extent that action has already been taken in reliance on the authorization.
- I understand that a mental health professional generally may not condition services upon my signing an authorization such as this.
- I understand that information used or disclosed according to the authorization may be re-disclosed by the recipient and may no longer be protected by the HIPAA Privacy Rule.

_______________________________________ _______________________________________

Signature of patient if 16 years of age or older
(parent or legal guardian if under 16 years of age)

Relationship to patient

_______________________________________ _______________________________________

Date

Witness