Tennessee Department of Human Services

HIPAA Authorization For Release Of Medical/Health Information To 3rd Party

Information will be released for: **PRINT NAME►**	**Date:**	**Identify Signer:** ☐ Self ☐ Parent of minor ☐ Guardian ☐ Other authorized representative (explain) * Proof of legal authorization may be required.
Street Address		**(Parent/guardian sign here if two signatures required by State law)**

Phone Number (with area code)	**City**	**State**	**Zip**

I give permission for the following medical/health records about me to be released by the Tennessee Department of Human Services (TDHS) and its authorized agents/contractors to the persons/organizations and for the purposes described below:

TDHS may release any and all medical / health records: _____ **Initial if "Yes"**

TDHS may release any and all mental health records: _____ **Initial if "Yes"**

TDHS may release drug or alcohol treatment / referral records: _____ **Initial if "Yes"**

TDHS may release HIV / AIDS test / treatment records: _____ **Initial if "Yes"**

You can also provide a specific description of medical/health information to be released. *Additional approval required for certain records.

My medical/health records will be used for the following purposes:

YOU DO NOT HAVE TO AGREE TO RELEASE YOUR RECORDS.

If you do not agree to release of your records to us, or if you take back your permission, TDHS may not be able to able to decide the case on time or may have to deny benefits.

- For the medical/health records you have given permission to be disclosed, TDHS can talk to, or give copies of my medical/health records to any of the person/organizations I have permitted.
- TDHS may make copies of this form and may also use a computer, electronic, and/or fax copy.
- You will get a copy of this form after you sign it. You can ask TDHS to let you see a copy of the information it sends after you sign this form.
- **This permission is good for twelve (12) months from the date you sign this form, unless you take back your permission sooner.**
- **You have the right to withdraw your permission at any time. *You cannot take back information that has been used to take action on your case or that has been given to us before you take back your permission.***
- **To take back your permission, you can *write* TDHS in your county, or *write* your doctors, hospitals or other health care providers or insurance company or health plan to take back your permission at any time.**
- All information provided to TDHS is protected by the Privacy Act of 1974 and federal or state law or regulations. It will not be given to other persons or organizations unless the law or regulations allow or require us to give out that information, or you allow us to give out that information. If we are required or permitted to give out the information, it may not be protected if the person or organization that receives it is not required by law to protect the information.
- **We may also use your information when we compare records by computer.** The computer matches our information with other federal, state or local government agencies. Many agencies use matching information to find out if a person gets benefits paid by the federal or state government. The matches also help prove that a person is eligible for help. The law lets us do this even if you do not agree to it.
- **You can ask TDHS to explain if you have questions about how or why your information is used.**

Signature of Person or Person's Authorized Representative: _____ **Date:** _____

***Witness:** _____ **Date:** _____

(To be signed if the person or authorized representative signs with an "X")

This authorization was developed to comply with the provisions regarding disclosure of medical/health information under P. L. 104-191 ("HIPAA"); 45 Code of Federal Regulations parts 160 and 164; 42 U.S. Code Section 290dd-2; 42 CFR part 2.31; 38 U.S. Code section 7332 and T.C.A § 68-10.

TDHS staff should check the "Forms" section of the intranet to ensure the use of current versions. Forms may not be altered without prior approval.

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