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:

- ***Specific Description of medical/health information to be provided*** **Additional approval required for certain records*)

_____
_____
_____
_____

- ***TDHS can also release drug or alcohol treatment/referral records: Yes:_____ No:____**
- ***TDHS can also release HIV/AIDS test/treatment records: Yes _____ No:_____**
- ***TDHS can release my medical/health information to the following persons/organizations:***

_____
_____
_____
_____
_____

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

_____
_____
_____

For the medical/health records I 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 and can give this information by paper, fax, computer or electronic copies of those records.

YOU DO NOT HAVE TO SIGN THIS FORM. ***I understand that my eligibility for benefits or services from the Tennessee Department of Human Services will not be affected if I do not sign this form.***

- I will get a copy of this form after I sign it. I can ask TDHS to let me see a copy of the information it sends after I sign this form.
- **This permission is good for 12 months from the date I sign this form, unless I take back my permission sooner.**
- **You have the right to withdraw your permission at any time.** ***You cannot take back information that has been given to other persons/organizations before you take back your permission and it will not affect any actions taken before you take back your permission.***
- **To take back your permission to let us give your medical/health records to other persons/organizations, you can *write* TDHS in your county, or *write* the persons/organizations that you have said we can give your information to. I understand that the person or organization that I have given permission to get my medical/health information may not be required by law to protect that information under federal or state law or regulations.**
- Ask TDHS to explain if you have questions about what information was given to any person or organization.

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

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 § 68-10-113.