DEPARTMENT OF
DISABILTY & AGING

AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION

CHILD OR PERSON SUPPORTED INFORMATION

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Previous Name/Alias: _____ Last 4 of SSN: _____ Phone: _____

I REQUEST AND AUTHORIZE (*check all that apply*)

☐ DDA

☐ DDA Facility _____

☐ TEIS (Tennessee Early Intervention System)

☐ DDA or TEIS Contract Provider _____

☐ Independent Support Coordinator (ISC) _____

☐ Other _____

to release the PHI, including early intervention services information pertaining to the above-named Child or Person Supported.

RECORDS / INFORMATION ARE TO BE RELEASED TO

Name / Agency / Class of Persons or Entities: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

DELIVERY METHOD RECORDS / INFORMATION TO BE RECEIVED BY *(Records requestor complete)*

☐ Mail ☐ In Person ☐ Email ☐ Fax ☐ Cloud (*ex: Dropbox*) ☐ Oral / Verbal ☐ TEIS Data System

Is this a request for psychotherapy notes? ☐ Yes ☐ No

If **Yes**, then this is the only item that may be requested with this form. A separate authorization is required for additional medical records.

REQUESTED INFORMATION

Dates of treatment or Service Records to be released include: (*Records requestor check one*)

☐ Records for **ALL** dates of treatment / services

☐ The specific dates listed below:

_____ to _____ or Specific date of: _____

_____ to _____ or Specific date of: _____

_____ to _____ or Specific date of: _____

MATERIALS TO BE RELEASED

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(CONTINUED)

PURPOSE OF RELEASE

- ☐ Patient Care
- ☐ Appointment / Sharing with other Health Care Provider as needed
- ☐ Personal Use
- ☐ Disability/Insurance Application Claim
- ☐ Administrative
- ☐ Attorney / Legal Case
- ☐ Research
- ☐ Provision of Early Intervention Services
- ☐ Other *(Specify)* _____

AUTHORIZATION FOR RELEASE

I understand that my medical records and/or early intervention service records may include information on diagnosis or treatment related to psychiatric or psychological conditions, drug or alcohol abuse; acquired immune deficiency syndrome ("AIDS") or HIV status, Hepatitis, COVID-19, and other infection diseases. I agree that any information about such diagnosis or treatment may be released.

PLEASE INITIAL THE STATEMENT BELOW AS IT APPLIES

_____ **I DO** or _____ **I DO NOT** authorize this information to be released. *(You MUST initial one)*

I would like to limit the information to *(Specify)*:

_____

THIS AUTHORIZATION WILL EXPIRE WHEN: (*check one*)

- ☐ The records are released for the request dated below
- ☐ Within 1 year of the signing of this authorization, unless specified otherwise
- ☐ On _____
- ☐ My child is no longer receiving TEIS services

I understand that:

- I may refuse to sign this authorization.
- Refusing to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits.
- I may take back (revoke) this authorization only in writing, but that won't impact actions already taken before my revocation is received.
- Any future requests not covered by this release will need a separate authorization.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy rules and might be shared with others.
- Sharing documents via unencrypted email and some Cloud services (Eg. Google Docs or Dropbox), may not be secure or compliant with HIPAA.
- I get a copy of this form after I sign it.

Signature of Person Supported or Legal Representative _____

Printed Name _____

Relationship to the Child or Person Supported: _____ **Date:** _____

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(CONTINUED)

PRIVACY OFFICER / TEIS STAFF / MEDICAL RECORDS USE

- Verified the Identity of the individual or personal representative. ☐ **YES** ☐ **NO**
- Request **approved** ☐ **YES** ☐ **NO**
- Response **delayed** ☐ **YES** ☐ **NO**
- Request **denied** ☐ **YES** ☐ **NO**

Response due date: _____

COMMENTS:

Signature of Privacy Officer, TEIS Staff, or Medical Records Staff: _____

Date: _____