AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
TENNESSEE DEPARTMENT OF HEALTH

Patient Name:	Date of Birth:	Social Security Number:

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with Tennessee state law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- Signing this authorization is a voluntary act. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- Information disclosed under this authorization may be re-disclosed by the recipient, and this re-disclosure may no longer be protected by federal or state law.
- I have the right to revoke this authorization at any time by writing to the county health department listed below. I understand that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.
- A copy of this authorization may be utilized with the same effectiveness as an original.

Name of entity authorized to release information:

_____

Information is to be released to:

_____

Name **Address**

Records authorized to be released: (Check all that apply. Records which are not checked will not be released.)

☐ COVID-19 Testing

This information will be used for the purpose of:

☐ Use by facility medical director for mitigating risk of COVID transmission

This authorization will expire on: (if no date is listed this authorization will expire within one year of signature)

_____

Month **Day** **Year**

_____

Patient or Representative Signature **Date**

_____ _____

Patient or Representative Printed Name **Relationship to Patient (if signed by representative)**