



**TENNESSEE DEPARTMENT OF HUMAN SERVICES  
HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL/HEALTH INFORMATION  
TO 3<sup>RD</sup> PARTY**

<b>Information will be released for:</b> PRINT NAME ►		<b>Date:</b>	<b>Identify Signer:</b> <input type="checkbox"/> Self <input type="checkbox"/> Parent of minor <input type="checkbox"/> Guardian <input type="checkbox"/> Other authorized representative (explain) *Proof of legal authorization may be required.	
<b>Street Address</b>		<b>(Parent/guardian sign here if two signatures required by State law)</b>		
<b>Phone Number (with area code)</b> (   )	<b>City</b>			

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)

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- \*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:

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

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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.