



DEPARTMENT OF
DISABILITY & 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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**AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION
(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 (<i>Specify</i>) _____ | |

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
- Request **denied** ☐ YES ☐ NO
- Response **delayed** ☐ YES ☐ NO

Response due date: _____

COMMENTS:

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

Date: _____