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 not checked will not be released.)

- ☐ All medical records and charts **including:**
- ☐ Sexually transmitted disease records including HIV and AIDS records
- ☐ Family planning records
- ☐ WIC records
- ☐ Psychiatric and other mental health records
- ☐ Genetic testing records
- ☐ Drug or alcohol records
- ☐ Other (please specify): Immunization Records

This information will be used for the purpose of:

- ☐ Personal use by patient or patient's representative
- ☐ Providing advocacy services
- ☐ Other (please specify):
- ☐ Verifying eligibility for services offered by: _____
- ☐ Legal representation, probation, parole, or law enforcement investigation

If no expiration date is specified below, this authorization will expire within one year of signature.

This authorization will expire on: _____ **Month** _____ **Day** _____ **Year**

_____

Patient or Representative Signature **Date**

_____ _____

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

PH-1778
(Rev. 02/2021)

RDA 150