Tennessee Baptist Children's Homes

TENNESSEE BAPTIST CHILDREN'S HOMES AS A CONTRACTED/LICENSED DCS AGENCY
Authorization for Release of Information and HIPAA Protected Health Information TO or FROM Tennessee Baptist Children's Homes/DCS and Notification of Release

A. AUTHORIZATION FOR RELEASE TO TBCH AND DCS

☐ I, _____ hereby authorize release of the information specified below, to any representative of Tennessee Baptist Children's Homes/DCS bearing this release or a copy of this release, including any information deemed to be confidential. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Tennessee Baptist Children's Homes/DCS. Failure to grant access to the requested information may result in a court order for the information

B. AUTHORIZATION FOR TBCH/DCS TO RELEASE

☐ I, _____ hereby authorize Tennessee Baptist Children's Homes/DCS to release the information specified below, to the person/entity specified below.
I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 2 of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

Name: *(Last)* *(First)* *(Middle)* | *Date of Birth* | *Social Security* | *Gender*

Other Legal Names: _____ Address: _____ Place of Birth: _____

Home Phone | *Cellular Phone* | *Work Phone* | *Alternate Phone*

Type of Information Requested (check ONLY one):

1. ☐ Education records, including transcripts, GED, TCAP, Special Education
2. ☐ Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.
3. ☐ Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.
4. ■ Background/Criminal History Checks, including Polygraph, and Fingerprint Results
5. ☐ Employment Records
6. ☐ Personal Finance/Credit History/Insurance Records (as applicable)
7. ☐ Other

AUTHORIZATION EXPIRES 1 YEAR FROM EXECUTION OF THIS DOCUMENT

Name of Provider/School/Entity Releasing Info to TBCH or Receiving info from TBCH:

Specific Information Requested:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ **OR** **This section was read to me. _____**

Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. <u>EXCEPTION:</u> Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

Signature	Print Name	Date

Signature of Witness	Print Name of Witness	Date