Tennessee Department of Children's Services

Authorization for Release of Information to the Department of Children's Services: TennCare Eligibility and Authorization for the Department of Children's Services to Release Information to TennCare

I hereby authorize representatives of the Tennessee Department of Children's Services, to include only the Health Advocacy Unit, Fiscal Team, Child-Benefit workers and case managers with applicable authority, bearing this release, or a copy of same, to obtain ONLY confidential TennCare **eligibility** information from your files. 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 Department of Children's Services within the scope of providing services to children.

I also authorize DCS to release the following information to TennCare or auditors of TennCare services, for the purpose of arranging, accessing, or obtaining services for my child, or proving that services were provided to my child: Child's name, SSN, DOB, Medicaid number, and diagnosis: type of service provided, provider information, and proof that the service was provided.

It has been explained to me, and I understand that there are statutes and regulations protecting the confidentiality of certain written and oral record information and that by signing this authorization only my eligibility status in TennCare will be released – no other TennCare records will be released for me. I can revoke my consent at any time. Should I choose to revoke this consent, I understand that the revocation must be in writing to be effective. I also understand that any release which has been made prior to my written revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization is valid until such request is fulfilled, but not to exceed one year from date of my signature. I understand that I may ask and receive a copy of this authorization. I hereby request and authorize the release of ONLY confidential TennCare **eligibility** information.

Identifying Information of Individual to Whom this Release Pertains:

Name: Last		**First**		**Middle**	
Address					
City		**State**		**Zip Code**	
SSN	- -	**DOB**		**Place of Birth**	☐ **Male** ☐ **Female**
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	( ) -
This form is effective from:	**Date:**	**to**	**Date:**		

Date not to exceed one year from begin date.

Signature: _____ **Date:** _____

Signature of Authorized Representative*: _____

Witness: _____ **Date:** _____

*Authorized Representative means you have legal proof you can act for this person. A representative signs for an applicant who may or may not legally sign on his or her own. We may have to get this proof from you.

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☐ **Unable to locate requested Information** ☐ **Requested information could not be released**

Reason			
Information released by		**Date**	
DCS Contact Person		**Telephone Number**	( ) -
DCS Office Address			

DCS Staff Requesting Release of TennCare Eligibility Info: _____ **Date:** _____

DCS Staff Who Accessed TennCare Eligibility Info: _____ **Date:** _____

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Child/Youth's Case File, Information Recipient

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