Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information TO the Department of Children's Services and Notification of Release

This information refers to the individual whose information is being released.

Name: Last		**First**		**Middle**	
Other Legal Names:					
Address					
City		**State**		**Zip Code**	
SSN		**DOB**		☐ **Male** ☐ **Female**	
Telephone Numbers: Cell		**Home**		**Work**	
This form's expiration date is:		**Date not to exceed one year from date of signature on this form. The expiration date should be 90 days from the date of signature if making a onetime request.**			

Name of Provider/School/Entity Releasing Information TO DCS:

_____

Type of Information Requested (check ONLY one) ***You must hand write/type in specific information being requested*:**

1. ☐ **Education records, including transcripts, GED, TCAP, Special Education**
   Specific Information Requested:
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*.**
   Specific Information Requested:
3. ☐ **Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
4. ☐ **Background/Criminal History Checks, including Polygraph, and Fingerprint Results**
   Specific Information Requested:
5. ☐ **Employment Records**
   Specific Information Requested:
6. ☐ **Personal Finance/Credit History/Insurance Records (as applicable)**
   Specific Information Requested:
7. ☐ **Other**
   Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ **Arrange/Access Services** ☐ **CPS Investigation** ☐ **Juvenile Court Case**
☐ **Other:** _____

One Signature Required:

Signature:_____ **Date:**_____

OR

Signature of Authorized Representative*:_____ **Date:**_____

*Authorized Representative means you have legal proof you can act for this person.

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A. AUTHORIZATION FOR RELEASE TO DCS

☐ **I, _____ hereby authorize release of the information specified on page 1A, to any representative of the Tennessee Department of Children's Services 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 Department of Children's Services. Failure to grant access to the requested information may result in a court order for the information.**

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 1A 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.

HIPAA Authorization for Release of Protected Health Information:

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. EXCEPTION: 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.

One signature required:

Print Name	*Signature*	*Date*

OR

Name of Authorized Representative (Print)	*Signature of Authorized Representative*	*Date*

Signer's Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐ Legal Custodian*	
☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Name of Witness (Print)	*Signature of Witness*	*Date*

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Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information FROM the Department of Children's Services and Notification of Release

This information refers to the individual whose information is being released.

Name: Last		**First**		**Middle**	
Other Legal Names:					
Address					
City		**State**		**Zip Code**	
SSN		**DOB**		☐ **Male** ☐ **Female**	
Telephone Numbers: Cell		**Home**		**Work**	
This form's expiration date is:		**Date not to exceed one year from date of signature on this form. The expiration date should be 90 days from the date of signature if making a onetime request.**			

Name of Provider/School/Entity Receiving Information FROM DCS::

Type of Information Requested (check ONLY one) ***You must hand write in specific information being requested*****:**

1. ☐ **Education records, including transcripts, GED, TCAP, Special Education**
   Specific Information Requested:
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*.**
   Specific Information Requested:
3. ☐ **Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
4. ☐ **Background/Criminal History Checks, including Polygraph, and Fingerprint Results**
   Specific Information Requested:
5. ☐ **Employment Records**
   Specific Information Requested:
6. ☐ **Personal Finance/Credit History/Insurance Records (as applicable)**
   Specific Information Requested:
7. ☐ **Other**
   Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ **Arrange/Access Services** ☐ **CPS Investigation** ☐ **Juvenile Court Case**
☐ **Other:** _____

One Signature Required:

Signature:_____ **Date:**_____

OR

Signature of Authorized Representative*:_____ **Date:**_____

*Authorized Representative means you have legal proof you can act for this person.

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B AUTHORIZATION FOR DCS FROM RELEASE

☐ **I, _____ hereby authorize the Tennessee Department of Children's Services to release the information specified on page 1, to the person/entity specified on page 1B.**

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 1B 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.

HIPAA Authorization for Release of Protected Health Information:

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. EXCEPTION: 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.

One signature required:

Print Name	*Signature*	*Date*

OR

Name of Authorized Representative (Print)	*Signature of Authorized Representative*	*Date*

Signer's Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐ Legal Custodian*	
☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Name of Witness (Print)	*Signature of Witness*	*Date*

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