



**Bureau of TennCare**  
**Permission to Release**  
**Protected Health Information**  
**(PHI)**

**After you fill out and sign this paper, send it to:**  
 Bureau of TennCare  
 Attn: Privacy Office  
 310 Great Circle Road  
 Nashville, TN 37243  
 Phone: 1-866-797-9469 Fax: 1-615-734-5289

**1. Who is the patient?**

Last Name		First Name		Middle Initial
ID Number (SSN)	Date of Birth (MM/DD/YYYY)	Phone Number (with area code)		
Address		City	State	Zip Code

Check One:

- I am the patient **OR**  
 I have the legal right to act for this person. (Check one below; if "other" fill in blank)  
 I am his or her:  Parent **OR**  Guardian **OR**  Other \_\_\_\_\_

**Only** TennCare or your TennCare providers can **give out** your health facts.

**2. Who can my health facts be given to?**

Name (like family members who live with me, or a place of business)	Phone Number (with area code)
Address	City, State, and Zip Code

**3. What health facts can we share?**

We'll **only** share the health facts you **OK**. Tell us the health facts from your records you say can be shared. Give the date or place if you can.

Health Facts	Date I got the care	Name of the place I got care from

**If you give us your OK to share this kind of health information, tell us by checking the box.**

- HIV/AIDS       Alcohol/Substance Abuse Records       Sexual/Physical/Mental Abuse  
 Mental Health Records       Other

This **OK** includes medicine you take now or have taken for the health facts you say we can share. AND, it includes facts in your record about your health and/or your alcohol and drug treatment. It doesn't include psycho-therapy notes that aren't in your medical records.

**4. Why are you giving out this health information?**

Is it to get health treatment, or for court or work? Or are you asking for these records to be sent directly to you for you to use?

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## 5. When does my OK end?

Your **OK** ends when you tell us it does. But, this **OK** can't be for more than 1 year. **Tell us when.**

My **OK** ends on this date \_\_\_\_\_ **OR**

My **OK** ends when this happens: \_\_\_\_\_

(It can be something like “you can share my medical records this one time.”)

What if you don't tell us when you want your **OK** to end? Then we will end your **OK** one year from when you sign. After one year, we will need a new **OK**.

## 6. Your Rights and Important Information

- Giving your **OK** is up to you. You don't have to share your health facts.
- You don't have to **OK** this paper. You will still get benefits and treatment.
- You can take back your **OK**. You must tell us in writing.  
Mail it to TennCare Privacy Officer, 310 Great Circle Road, Nashville, TN 37243.
- What if you take back your **OK**? It won't take back the health facts we have already shared. But, we **won't** share any more of your health facts.
- If we share your health facts with the people or agencies you named, they may share it with others. Not everyone has to follow privacy rules.

You have a right to get a copy of this signed **OK**. If you need another copy, call the TennCare Privacy Office at **1-866-797-9469**. We can charge for copies of records as allowed by law.

Do you have questions or need help with this paper? Call the Tennessee Health Connection for free at **1-855-259-0701**. They can help you Monday to Saturday from 7am to 7pm.

## 7. Signature of Patient

I give my **OK** to share the information listed in this paper. This paper can be an original or a copy.

**Sign Here:** \_\_\_\_\_  
Signature or Mark (“X”) of Patient

\_\_\_\_\_  
Date

( )

\_\_\_\_\_  
If signed “X” please tell us the person’s name who helped you.

\_\_\_\_\_  
Helper’s phone number

\_\_\_\_\_  
Helper’s Address, City, State, Zip Code

## 8. Signature of Authorized Representative (if you have one)

**Authorized Representative** means you have legal proof you can act for this person. You must give us a copy of this proof. A representative signs for a patient who may not legally sign on his or her own. If the patient is less than 18 years old, a parent or guardian should sign for the minor.

\_\_\_\_\_  
Signature of Person signing on behalf of patient

\_\_\_\_\_  
Date

( )

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address, City, State, Zip Code

### NOTICE TO ANY RECIPIENT OTHER THAN THE PATIENT

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.