Tennessee Department of Human Services

CREST Participant Authorization

☐ **RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND/OR HEALTH OPERATIONS:**

I understand that information collected on this form will be used by providers and funders of my services, and also may be used in statistical reports to government agencies. I give my permission to use the information for these purposes.

☐ **REQUEST FOR INTERAGENCY INFORMATION SHARING:**

I give permission and request the information from my records be shared with medical emergency response providers, and agencies from which I receive services that would otherwise have to interview me again to collect the same data.

☐ **AUTHORIZATION FOR REFERRAL FOR SERVICES:**

I give my permission for the CREST advocate to contact on my behalf the agencies or persons listed below and to release only such information to them as may be needed to determine or provide the level and types of services that I may need. I also grant permission to the receiving agencies to report back regarding services that I may or may not receive and/or any additional information that may significantly reflect on my need for services.

SPECIFY INDIVIDUALS/ENTITIES TO WHOM INFORMATION MAY BE RELEASED:

Name	_____	Relationship	_____	Phone	_____
Name	_____	Relationship	_____	Phone	_____
Name	_____	Relationship	_____	Phone	_____
Name	_____	Relationship	_____	Phone	_____
Name	_____	Relationship	_____	Phone	_____

Special Notes/Instructions:

☐ **GRIEVANCE PROCEDURE:**

I understand that if I have a serious complaint about not receiving adequate service from CREST and/or any agencies providing services which are funded in part by Federal or State funding, I have a right to complain to the proper authorities with no penalty to me.

☐ **CLIENT AGREEMENT:**

By my signature, I affirm that I have read, or have had explained to me, the above statements. The telephone number I need for complaints has been given to me, and I do give the authorization necessary for release of information as listed above. I authorize the use or disclosure of my personal health information as described above, where such permission is necessary beyond the sharing of my information for the normal course of business. Unless otherwise stated this release of information expires twelve (12) months from the latest date below.

I understand I have a right to cancel or change this consent at any time, but must notify my CREST advocate in writing to cancel or change the release.

Participant Signature	**Date**	**Advocate Signature**	**Date**
_____	_____	_____	_____