319 Ezell Pk
Nashville, TN 37217
Office (615) 399-3000

I hereby authorize the use or disclosure of my individually identifiable protected health information as described below. I understand that the authorization is voluntary and **I may refuse to sign it**. I understand that 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 confidential under *Tennessee Code Annotated* 33-3-105 or protected by federal privacy regulations, Health Insurance *Portability and Accountability Act of1996* (HIPPA).

Service Recipient's Name: _____ **DOB** _____

Facility Providing the Information: (Name/Address)	Person/Organization Receiving the Information (Name/Address)
_____	_____
_____	_____
_____	_____

The following specific information:

___ History and Physical
___ Medical Progress Notes
___ Laboratory/X-ray Reports
___ Speech and Hearing Reports
___ Psychological Evaluation
___ Immunization Record
___ Dental Records
___ Discharge Summary
___ Psychiatric Evaluation

___ Other: _____

For the purpose of:

___ Developing a diagnosis, treatment and support plan for me
___ Coordinating medical, psychological and social habilitation process for my care
___ Other: _____

The service recipient or the service recipient's parent/guardian (if minor), conservator, or legal representative must read and sign below, understanding the following:

- I understand that my health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form.
- I understand that I may see and copy the information described on this form, if I ask for it, and that I get a copy of this form after I sign it.
- I understand that this authorization will expire on ____/____/____ *(DDMMYY)*. If no date is specified, this authorization will expire in one year from the date of the signature below.
- I understand that I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do, it will not have any affect on any actions taken before I revoke the authorization.
- I understand that the facility has thirty (30) days in which to provide a copy of my records, and if records are stored off premises, sixty (60) days.

_____ _____
Signature of Service Recipient, Parent/Guardian, Conservator, or Representative
(Form MUST be completed before signing)
Date

Printed Name & Relationship of Service Recipient's Legal Representative: _____