Department of Health Care Finance and Administration, Division of TennCare

Permission to Release Member Information

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 member?

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 Member OR

☐ I have the legal right to act for this person. (Check one below; if "other" fill in blank.)

I'm the Member's: ☐Parent OR ☐Guardian OR ☐Other ________________

Only TennCare can **give out** your health facts using this form.

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 and records you allow and we have. Tell us the health facts and records you allow us to share. Give the date or place they come from if you can.

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

If you give us your OK to share these other kinds of health information, tell us by checking the boxes. ☐ HIV/AIDS ☐ Alcohol/Substance Abuse Records

☐ Sexual/Physical/Mental Abuse ☐ Mental Health Records ☐ Other

This **OK** includes information about medicine you take now or have taken for the health facts you say we can share. It also 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, for court or work? Or are you asking for these records to be sent directly to you for your own use?

____

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 TennCare Connect for free at **1-855-259-0701.** They can help you Monday to Friday from 7 AM to 7 PM.

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 MEMBER 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 use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Tennessee Health Care Finance and Administration
Authorization of Individual Representative

Section 1: Introduction

You must complete this form if you want **ANOTHER PERSON** to be your Representative and act on your behalf in applying for medical benefits and/or act for you on an ongoing basis regarding medical coverage from the State of Tennessee, Health Care Finance and Administration (HCFA). This includes programs such as TennCare Medicaid, CHOICES, CoverKids and emergency medical services (EMS). Both you and your Representative must sign and date this form.

Section 2: Representative

Name of Individual:	Phone Number:
Street Address:	City, State and Zip Code:
Relationship with applicant/recipient (e.g. Family Member, Friend, Attorney):	

Section 3: Function of Representative

I understand and voluntarily agree that my Representative is authorized to:

- Obtain from HCFA and submit to HCFA information about me with respect to my general and financial circumstances and medical condition;
- Complete, sign and submit an application and related documents on my behalf;
- Receive information regarding the status of my application and eligibility;
- Receive all notices or other communications regarding my application, appointments, redetermination or eligibility status;
- Accompany me or represent me for any required interview, hearing or appeal;
- Pursue the appeal process, up to and including legal proceedings, in the event my application is denied;
- Act on my behalf in all other matters related to my eligibility determination.

Section 4: Medical Information

- I voluntarily authorize and request disclosure by HCFA of all my medical information to my Representative for the purpose of assisting me with the eligibility determination process and other related functions listed above.
- I understand this may include information regarding medication I take now or have taken in the past and may include facts regarding my health and/or present or past alcohol or drug treatment. It does not include psycho-therapy notes that are not in my medical records.
- I understand my eligibility and ability to obtain health care and coverage does not depend on my granting this authorization.
- I understand that information shared by my Representative may be shared with others. Not everyone has to follow privacy rules.
- My authorization for HCFA to release medical information to my Representative expires upon the written termination of this authorization as described in Section 5.

Puede obtener estas hojas en español. Visite nuestro sitio web en www.tennessee.gov/tenncare. O bien, llame Tennessee Health Connection al 1-855-259-0701.

Section 5: Termination of Authorization

You can terminate this authorization at any time by giving HCFA written notice that your Representative is no longer authorized to act on your behalf. This will not change facts we have already shared with your Representative, but we won't share any more health facts.

Section 6: Signature of Representative

In agreeing to be an authorized representative, I understand that I am expected to be knowledgeable of the applicant's/recipient's circumstances and that this authorization can be revoked by the applicant/recipient at any time. I also agree to maintain the confidentiality of any information provided to me, including but not limited to health and financial information pursuant to all applicable state and federal rules and regulations.

Signature of Representative:	Date:

Section 7: Signature of Applicant/Recipient

I authorize this Representative to act for me regarding eligibility and related functions listed in Section 3. I understand that I am responsible for the information anyone acting as my authorized representative gives and I may be required to cooperate further, including providing information and documents. I also understand that I can terminate this authorization at any time by giving HCFA written notice that my Representative is no longer authorized to act on my behalf.

Name of Applicant/Recipient (Last, First, Middle Initial):	Phone Number:
ID Number (SSN):	Date of Birth (MM/DD/YYYY):
Address:	City, State and Zip Code:
Signature of Applicant/Recipient:	Date:

If applicant/recipient is not able to sign, an authorized representative may sign and provide legal documentation of authority (e.g. power of attorney, custody documentation).

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Tennessee Health Care Finance and Administration
Authorization of Representative Organization

You must complete this form if you want an **ORGANIZATION** to represent you and act on your behalf in applying for medical benefits and/or act for you on an ongoing basis regarding medical coverage from the State of Tennessee, Health Care Finance and Administration (HCFA). This includes programs such as TennCare Medicaid, CHOICES, CoverKids and emergency medical services (EMS). Both you and a member of the organization must sign and date this form.

Applicant/Recipient

Name of Applicant/Recipient (Last, First, Middle Initial):	Phone Number:
ID Number (SSN):	Date of Birth (MM/DD/YYYY):
Address:	City, State and Zip Code:

Scope of Authorization

I understand and voluntarily agree that my Representative Organization is authorized to:

- Obtain from HCFA and submit to HCFA information about me with respect to my general and financial circumstances and medical condition;
- Complete, sign and submit an application and related documents on my behalf;
- Receive information regarding the status of my application and eligibility;
- Receive all notices or other communications regarding my application, appointments, redetermination or eligibility status;
- Accompany me or represent me for any required interview, hearing or appeal;
- Pursue the appeal process, up to and including legal proceedings, in the event my application is denied;
- Act on my behalf in all other matters related to my eligibility determination.

Medical Information

- I voluntarily authorize and request disclosure by HCFA of all my medical information to my Representative Organization and its employees for the purpose of assisting me with the eligibility determination process and other related functions listed above.
- I understand this may include information regarding medication I take now or have taken in the past and may include facts regarding my health and/or present or past alcohol or drug treatment. It does not include psycho-therapy notes that are not in my medical records.
- I understand my eligibility and ability to obtain health care and coverage does not depend on my granting this authorization.
- I understand that information shared by my Representative may be shared with others. Not everyone has to follow privacy rules.
- My authorization for HCFA to release medical information to my Representative Organization expires upon the written termination of this Authorization.

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Termination of Authorization

You can terminate this authorization at any time by giving HCFA written notice that your Representative Organization is no longer authorized to act on your behalf. This will not change facts we have already shared with your Representative Organization, but we won't share any more facts.

Signature of Representative Organization Employee

The authorized Representative Organization understands it is expected to be knowledgeable of the applicant's/recipient's circumstances and that this authorization can be revoked by the applicant/recipient at any time. The Representative Organization agrees to protect and maintain the confidentiality of any information provided to it, including individually identifiable health information and financial information of the applicant, pursuant to the regulations set forth in 42 CFR 435.923; 42 CFR 431 subpart f; 45 CFR 155.260(f), 42 CFR 447.10, as well as other relevant state and federal laws. The Representative Organization also agrees to promptly provide to the Applicant/Recipient copies or originals of all relevant documents, communications and mailing enclosures received from HCFA related to the purposes specified in this authorization.

Organization Name:	
Address:	City, State and Zip Code:
Organization Type (Eligibility Assistance Company, Institution):	
Name of Organization Authorized Employee:	Title:
Email:	Phone Number:
Signature of Organization Authorized Employee:	Date:

Signature of Applicant/Recipient

I authorize this Representative Organization to act for me regarding eligibility and related functions listed above. I understand that I am responsible for the information anyone acting as my authorized representative gives and I may be required to cooperate further, including providing information and documents. I understand that I can terminate this authorization at any time by giving HCFA written notice that my Representative Organization is no longer authorized to act on my behalf. I also understand that my Representative Organization can withdraw as my representative at any time by notifying HCFA in writing and shall also notify me in writing of such withdrawal.

I understand that the Organization may receive payment from my healthcare provider, such as a hospital where I received treatment, to provide these assistance services on my behalf. I understand that the outcome of any eligibility determination regarding my application cannot be guaranteed by the Representative Organization.

Signature of Applicant/Recipient:	Date:

If applicant/recipient is not able to sign, an authorized representative may sign and provide legal documentation of authority (e.g. power of attorney, custody documentation).

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