RELEASE OF HEALTH INFORMATION
TENNESSEE DEPARTMENT OF CHILDREN'S SERVICES

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION OR HEALTH RECORDS UNDER THE PROTECTION OF FEDERAL LAW, TITLE 42, CFR CHAPTER II PART II

Name: _____ Number: _____
first middle last

Birthdate: _____ Social Security No. _____ Sex: _____

Parent's Name: _____

Pursuant to Federal Guidelines concerning my right to confidentiality, I, _____
(name of client)
authorize _____ to release my health records or information concerning my
(name of specific person or organization)

health records to _____
(name of specific person or organization)

I specifically consent only to the release of information or health records pertaining to:

The following information: **__Behavioral** **___Medical** **?___Dental** **___All of the below**
___ prior assessments ___ recommendations ___ closing summaries
___ progress notes ___ treatment provided ___ medical
___ opinions regarding parent competence
___ other relevant information, medical or psychological

I understand that I may revoke this consent to release of information at any time; however, I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire when:

_____

_____
(date, event, condition or expiration)

At that time no express revocation shall be needed to terminate my consent; however revocation of consent at any other time must be provided in writing.

_____ _____
client's signature date

_____ _____
witness date

(A youth aged 16 or older may sign for themselves; the case manager or foster parent may sign for any custodial youth in their care.)

_____ _____
Custodial agent date

Original: Recipient
Copy: Health Record