# AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Purpose and Laws: This form, when properly completed, permits the release of confidential information about a person receiving services (service recipient) governed and regulated by Title 33, Tennessee Code Annotated. Any information to be released under this form shall be released in accordance with the following confidentiality laws and regulations: Title 33, Tennessee Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. The records released through this Authorization are protected by the above named confidentiality laws and regulations. A general authorization for the release of medical or other information is NOT sufficient for the purpose of disclosing mental health or alcohol and substance abuse information. Federal rules restrict any use of alcohol and substance abuse information to criminally investigate or prosecute the person to whom the information pertains. Further disclosure of this information to parties other than those designated on this form is expressly prohibited without the express written consent of the person to whom the information pertains.

I,_____/_____, authorize
(Print Name & Social Security Number of service recipient) (Print date of birth and phone number)

**The University of Tennessee Student Health Center Psychiatry Clinic** / **UT Student Health Center, 1800 Volunteer Blvd., Knoxville, TN 37996**
(Print name of agency/program making disclosure) and (Mailing address of agency/program making disclosure)

To disclose to The University of Tennessee Student Counseling Center / UT Student Counseling Center, 1800 Volunteer Blvd., Knoxville, TN 37996
(Print name of person(s)/organization to which disclosure is to be made, and their mailing address or fax number and phone number.)

The following information: Attendance only / Date(s) of attendance / Diagnosis
Treatment Summary / Other: _____
(Circle/Describe the specific information to be used or disclosed)

The purpose of the authorized disclosure is to: Continuity of care / Other: _____

_____
(Specific purpose/use of the disclosure)

By signing this form, I (the service recipient) understand that if the person or organization designated on this form to receive the information is not a Health Plan or Health Care Provider, some of the released information may no longer be protected by the above named confidentiality laws and regulations. I also understand that signing this Authorization is voluntary, and that I am not required to sign this Authorization in order to get treatment, payment, enrollment, or eligibility for benefits. I also understand that I may revoke this Authorization by doing so in writing at any time; except to the extent that action has been taken in reliance on the information, and that the revocation does not affect any information that was released before the revocation. Even if I do not revoke this Authorization, **the Authorization expires automatically one (1) year from the date of signature or as follows:**

_____
(Specify the date, event, or condition of expiration)

_____ _____
**(Signature of service recipient who is 16 years of age or older)*** **(Date)**

*If a service recipient gives oral consent or signs with an X, this form must be signed by two (2) witnesses, otherwise only one (1) witness signature is required:

_____ _____
(Witness) (Date) (Witness) (Date)

_____ _____
**(Signature of individual acting on behalf of the service recipient)**** **(Date)**

** If the individual signing this form is acting on behalf of the service recipient, the individual is: (1) the parent, legal guardian, or legal custodian of a service recipient who is under 18 years of age; (2) the conservator or guardian for the service recipient; (3) the *guardian ad litem* of the service recipient but only for the purposes of the litigation in which the *guardian ad litem* serves; (4) the attorney-in-fact under a power of attorney who has the right to make disclosures under the power for the service recipient; (5) the executor, administrator, or personal representative on behalf of a deceased service recipient; and (6) the treatment review committee, acting within the authority and scope of Tennessee Code Annotated Section 33-6-107. Appropriate documentation of proof of this individual's authority to act on behalf of the service recipient must be submitted to the entity being asked to release the information **before** any information will be released.