

Department of Children's Services
INSTRUCTIONS FOR USE OF FORM
CS-0668, Authorization for Release of Information and HIPAA Protected Health Information
TO THE
DEPARTMENT OF CHILDREN'S SERVICES

Use this form to **RECEIVE** information or records needed on children/youth or parents, foster parents or other individuals as applicable.

Use this form to **RECEIVE** educational and criminal background checks information and records on employees or volunteers. This form may **not** be used to obtain **Medical** and **Psychological information** on employees or volunteers. For this type of information regarding employees or volunteers, consult with the appropriate DCS Human Resources Representative or contact the DCS Office of Human Resources.

This form must be filled in completely. Areas throughout the form (including the HIPAA section) that provides boxes where a "Yes" or "No" response is requested **must** be checked "Yes" or "No".

Each area of the form that requires an "Authorizing Signature, Witness Signature and Date" **must** be completed.

***HIPAA Authorization for Release of Protected Health Information**

Complete the *HIPAA Section on this form when the client/his personal representative requests/wishes DCS to receive protected health information (PHI) records from another person/organization.

- **Notes:**
1. The client or the client's authorized representative must approve and sign this form before any PHI information is released to the requesting person/entity. Exception: If the child is age 14 or older, they may sign the form.
 2. The maximum length of time a form may remain valid is one year from the begin date if certain information is requested on a recurring basis. If information is requested on a one-time basis, the form is effective for ninety (90) days from the begin date.
 3. In all cases the parent/guardian is the authorizing agent unless the child is in full guardianship. If the child is in full guardianship and under age 14, DCS is the authorizing agent.
 4. For additional questions regarding the completion of this form, contact the local DCS Regional Counsel.



Tennessee Department of Children's Services
Authorization for Release of Information and HIPAA Protected Health
Information to the Department of Children's Services and Notification of
Release

I hereby authorize any representative of the Tennessee Department of Children's Services bearing this release, or a copy of same, to obtain information from your files, including any information deemed to be confidential. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services. Failure to grant access to needed information to provide services may result in a court-ordered request for information

It has been explained to me, and I understand that there are statutes and regulations protecting the confidentiality of certain written and oral record information. 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 is valid until such request is fulfilled, but not to exceed one (1) year from *date of my signature. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified below:

Name: (Last) _____ (First) _____ (Middle) _____ Date of Birth _____ / / _____ Social Security No. _____ - - _____ Gender _____

Address: _____ Place of Birth: _____ ID No. _____

() - _____ () - _____ () - _____ () - _____

Home Telephone No. Cellular Telephone No. Work Telephone No. Alternate Telephone No.

(If The Requestor is a Child Under the Age of Legal Consent (18), the Child's Parent(s) or Legal Guardian Must Sign This Release.)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Education records, including transcripts, GED, TCAP, Special Education
<input type="checkbox"/>	<input type="checkbox"/>	2. Medical records, including examinations, laboratory tests, and prescribed treatments (List specific medical information needed). <i>Does not apply to employees or volunteers.</i>
<input type="checkbox"/>	<input type="checkbox"/>	3. Psychological/Psychiatric/Mental Health Treatment Records, including any associated test results. List specific Psychological/Psychiatric/Mental Health Treatment information needed). <i>Does not apply to employees or volunteers.</i>
<input type="checkbox"/>	<input type="checkbox"/>	4. Employment Records
<input type="checkbox"/>	<input type="checkbox"/>	5. Background/Criminal History Checks, including Polygraph, and Fingerprint Results
<input type="checkbox"/>	<input type="checkbox"/>	6. Personal Finance/Credit History/Insurance Records (as applicable)
<input type="checkbox"/>	<input type="checkbox"/>	7. Other – Specify: _____ Contacts with References

 Authorizing Signature

_____/_____/_____
 Date

 Signature of Witness

_____/_____/_____
 Date