STATE OF TENNESSEE
DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTALDISABILITIES
AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable protected health information as described below. I understand that this 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 of 1996 (HIPAA).

Service Recipient's
Name: _____ D.O.B. _____

Facility Providing the Information:
(Name/Address)

Department of Intellectual and
Developmental Disabilities (WTRO)
11437 Milton Wilson Rd.
P.O. Box 949
Arlington, TN 38002

Person/Organization(s) receiving information:
(Name/Address/Waiver Services Offered -if applicable)

Kimler, David DDS PLLC
2900 S. Perkins Rd.
Memphis, TN
38118

Specific description of and purpose for the information (including date(s) to be provided:
To provide summary profiles, psychological, evaluation, and any identifying information on this Individual for the purpose of determining eligibility for support services through DIDD.

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.
- I understand that this authorization will expire on (_____)
  If no date is specified, this authorization will expire in ninety (90 days) 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 revoked 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, **Date**
Conservator or Representative
(Form MUST be completed before signing)

Printed name of Service Recipient's Legal Representative: _____

Relationship to the Service Recipient: _____