State of Tennessee

Department of Intellectual and Developmental Disabilities

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable protected health information (PHI) as described below. I understand that this authorization is voluntary, and **I may refuse to sign it**. I understand that if the person authorized to receive the information is not a health plan or health care provider, the release information may no longer be confidential under Tennessee Code Annotated 33-3-104 or prohibited 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)	Person/Organization Receiving Information: (Name/Address/Waiver of Services if Applicable)
Department of Intellectual and Developmental Disabilities (WTRO)	**David M. Kimler Dentistry, PLLC**
11437 Milton Wilson Rd.	**6500 Stage Road, Suite 1**
Arlington, TN 38002	**Bartlett, TN 38134**

Specific description of and purpose for the information including date(s) to be provided:

To provide summary profiles, psychological evaluation, and identifying information on this individual for the purpose of determining eligibility for support services through Intellectual and Developmental Disabilities (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 sign this form.
- I understand that I may see and copy the information described in 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 ninety (90) days from the date of signature below.
- I understand that I may revoke this authorization at any time by notifying the person/organization in writing, but if I do, it will not have any affect on any actions taken BEFORE I request to revoke the authorization.
- I understand that if requested, the facility has thirty (30) days in which to provide a copy of my records, and if records are stored off the premises sixty (60) days.

______________________________________ ____________________

Signature of Service Recipient, Parent/Guardian Conservator or Representative — Date of Signing

Printed Name of Service Recipient's Representative: ______________________________

Relationship to Service Recipient: ______________________________