



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BENEFITS ADMINISTRATION

312 Rosa L. Parks Avenue
Suite 2600 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
Phone (615) 741-4517 or (800) 253-9981
FAX (615) 253-8556

**AUTHORIZATION FORM
FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I, _____, Edison system identification number _____ or Social Security Number _____, give permission to the Tennessee Department of Finance and Administration, Benefits Administration; and business associates creating or maintaining Protected Health Information on its behalf, to:

use the following protected health information, and/or

disclose the following protected health information to:

Name(s) of person(s) or class of persons to whom I will allow my PHI to be released

Information to be disclosed (check all that apply):

Insurance Records with Benefits Administration

Other:

This protected health information is being used or disclosed for the following purposes:

a. _____ at the request of our covered participant

b. _____

List reason why information is being used or disclosed (i.e. – Legal reason.....)

This authorization expires

Must provide an end date (MM/DD/YYYY) ____/____/____ or expiration event

You may revoke this authorization in writing at any time by sending written notification to:

Bob Smith, Benefits Administration HIPAA Privacy Officer
312 Rosa L Parks Ave
Suite 2600 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243

Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment of payment or your eligibility for benefits.

Signature of Participant or Personal representative

Date

Printed name of Participant or personal Representative

Description of Personal Representative's Authority