AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name	Date of Birth	Patient Identification Number

Patient Address

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form in accordance with Tennessee state law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which is federal law that protects certain health information from unauthorized disclosure.

Specific information to be released and discussed:

- ☐ Entire medical record (written and oral) including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consulting, billing records, insurance records and records send to you by other health care providers.
- ☐ Release and discuss only my medical record from (insert date) ______ to (insert date) ______
- ☐ Other: ______

Include: (*Indicate by initialing*)
HIV/AIDS-related information

______

REASON FOR RELEASE OF INFORMATION:
Coordination of services, including HIV-prevention and/or care between providers in the Get PrEP TN Network when the team involves more than one agency.

Date of event on which the authorization will expire:

Understanding your rights:

1. If I am authorizing the release of HIV/AIDS-related information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of the people who may receive or use my HIV/AIDS-related information without my authorization. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the U.S. Department of Health and Human Services at 800-368-1019 or the Tennessee Human Rights Commission at 800-251-3589. These agencies are responsible for protecting my rights.
2. I have the right to revoke this authorization at any time by writing to the health care providers listed above. I understand that I may revoke the authorization except to the extent that action has already been taken based on this authorization.
3. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
4. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in item 1), and this redisclosure may no longer be protected by federal or state law.

All items on this form have been completed, my questions about this form have been answered, and I have been provided a copy of the form.

If not the patient, name of person signing form:	Authority to sign on behalf of patient:

SIGNATURE OF PATIENT OR REPRESENTATIVE BY LAW DATE

PRINT NAME

NAVIGATION CONSENT

DATE / /

1. **Navigation Relationship:** Navigation is a process in which you, "the client," and I, "the Navigator," work as a team to identify and work toward resolving your health needs.
2. **Areas of Expertise and Services:** My current emphasis is working with clients to prevent infection with STDs and HIV and/or assisting clients with their HIV or PrEP treatment regimen. I provide navigation services to clients in need of support services to help prevent STDs and HIV.
3. **Fee Scales:** I do not charge a fee for my services in my position. All my services are free of charge and voluntary.
4. **Privileged Communications:** Materials revealed while the client is enrolled in navigation will remain strictly confidential except for the following circumstances in accordance with state law:
    - a) The client signs a written release of information indicating informed consent of such release.
    - b) The client expresses intent to harm him/herself or someone else.
    - c) There is a reasonable suspicion of abuse/neglect against a minor child, elderly person (age 60 or older) or a dependent adult.
    - d) A court order is received directing the disclosure of information.

It is my policy to assert privileged communications on behalf of the client and the right to consult with the clients if at all possible, except during an emergency, before mandated disclosure. I will endeavor to apprise clients of all mandated disclosures as conceivable.

5. **Emergency Situations:** Should you believe you are in need of immediate help, you may seek that help through hospital emergency room facilities or by calling 911.
6. **Client Rights:**
    - a) **Respect, Courtesy and Confidentiality:** You have the right to be treated at all times with respect and courtesy within a setting that provides you with the highest degree of privacy possible.
    - b) **Consumer Grievance Procedure:** As we work together, if you have suggestions or concerns about your navigation process, you may share these with me so that we can make the necessary changes.
    - c) You have the right to file a grievance. Contact the agency below:

    Navigator Agency: Phone Number: Email:

7. **Client Responsibilities:**
    - a) **Respect, Courtesy and Confidentiality:** Health and social service providers have the right to be treated with respect and courtesy at all times.
    - b) **Giving Correct and Complete Information:** You are responsible for giving to your provider accurate and complete information about your health condition and social situation, medication use, past and current treatment, and the names and addresses of other providers you are using or have used.
8. **Discharge From Program:**
    - a) If at any time the agreement that we have is broken, you will be discharged from the navigation program.
    - b) If you are able to continue on without the help of the navigator, you may be discharged from the navigation program.

I have read and understand the above information.

Client's Name Client's Signature Date

Navigator's Name Navigator's Signature Date