TENNESSEE DENTAL ASSOCIATION PATIENT REQUEST FOR MEDIATION

Upon receipt of this completed form, a mediator will be assigned and will contact you to discuss your request and attempt to resolve the issue. Please state your complaint concisely on a separate page. Note: Mediation is designed to address the complaint of dental treatment between patient and dentist only.

Date	[Case #	(TDA office use only)]
Name			_
Address			
City	State	Zip	
Please provide below a phone numbe contact you.	r and the best time of	day when the mediator will be able	to
Day Phone ()	Time_		
Night Phone ()	Time_		
Dentist Information: (MUST)	PROVIDE DENTIS	T'S FIRST AND LAST NAME)	
Name	Phone number		
Address			
City	State	Zip	
Date of last appointment			

Please read and sign the reverse side regarding release of information.

State your complaint on a separate page and attach to this form.

Return completed form to:

Patient Information:

TDA PEER REVIEW, 660 Bakers Bridge Avenue Suite 300, Franklin, TN 37067

Authorization to Use and Disclose Health Information

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Name
Dentist
I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.
Information to be used or disclosed: any and all information related to treatment provided to me by the above-named dentist regarding treatment as it relates to the attached complaint.
Purpose for Disclosure: mediation, peer review, and any peer review appeal.
I authorize the following person(s) to make the requested use or disclosure of the above health information: Dentist and any workforce member of Dentist's practice.
Person(s) receiving my authorized information include the Tennessee Dental Association Peer Review Committee, including any appointed mediator, peer review committee members, specialty panel members, and any other individuals whose review of the authorized information is necessary or appropriate to the mediation, peer review, and/or peer review appeal process.
I understand that I may revoke this authorization at any time by sending written notice to: Tennessee Dental Association/Peer Review Committee, 660 Bakers Bridge Avenue, Suite 300, Franklin, TN 37067.
If I choose to revoke this authorization, my revocation will not affect any actions that were taken before written notice of my revocation was received. I understand that if I refuse to sign or revoke this authorization, I may not be able to participate in mediation, peer review, and/or appeal.
Signature of patient or patient's personal representative Date
If personal representative, print name:
Relationship to patient: