TDA-DPWC
Dental Professionals
Wellness Committee

660 Bakers Bridge Ave., Suite 300 • Franklin, TN 37067 • (615) 628-3200

Authorization and Consent for Release of Information
From TDA-WC

1. I, ____ authorize
   (Participant's Name)

   The Tennessee Dental Association Wellness Committee Program's staff

2. TO DISCLOSE/RELEASE
   (Please check all that are appropriate)

   ❑ Copy(ies) or summary(ies) of information pertinent to TDA-CDPC participation, compliance, aftercare, along with other treatment/assessment facility's information/recommendations.

   ❑ To Re-disclose ____
   (Note: Once re-disclosed, information may not be HIPAA protected.)

   ❑ Other ____

3.TO: ____
(Name or description of program/entity/individual(s) receiving the disclosure.)

4. PURPOSE:

   ❑ To facilitate case management, advocacy efforts and/or aftercare follow-up.

   ❑ Other ____

5. Participant's Signature ____

6. Date of Signature ______________________________

EXPIRATION: This consent is subject to written revocation at any time except to the extent that the TDA-DPWC, which is to make this disclosure, has already taken action in reliance on this Authorization/ Consent. The TDA-DPWC reserves the right to change its privacy practice. The participant may request a restriction of the use of covered information, but, unless it agrees, the TDA-DPWC is not required to honor that request. If not previously revoked, this consent will terminate thirty (30) days after successful completion of TDA-DPWC participation or aftercare contract, unless another date is indicated below:

______ / ______ / ______

TDA-DPWC
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Wellness Committee

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Authorization and Consent for Release of Information
To TDA-DPWC

1. I,______________________ , authorize
   (Participant's Name)

2. ___________________________________
   (Name or description of program making the disclosure)

3. TO DISCLOSE/RELEASE *(Please check all that are appropriate)*
   - ❑ Treatment and discharge summary reports including recommendations
   - ❑ Evaluations including urine results and reports including recommendations
   - ❑ Clinical updates
   - ❑ To Re-disclose
   - ❑ Other

   ____

4. TO: The TDA Concerned Dental Professionals Program and its staff and applicable RAM team

5. PURPOSE:

   - ❑ To facilitate case management and advocacy efforts

   - ❑ Other ____

6. Participant's Signature ____

7. Date of Signature ___________________________________

EXPIRATION: This consent is subject to written revocation at any time except to the extent that the TDA-DPWC, which is to make this disclosure, has already taken action in reliance on this Authorization/ Consent. The TDA-DPWC reserves the right to change its privacy practice. The participant may request a restriction of the use of covered information, but, unless it agrees, the TDA-DPWC is not required to honor that request. If not previously revoked, this consent will terminate thirty (30) days after successful completion of TDA-DPWC participation or aftercare contract, unless another date is indicated below:

______ / ______ / _____