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:

_____ / _____ / _____
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:
______ / ______ / _____