

Authorization and Consent for Release of Information
(Released to the Tennessee Dental
Wellness Foundation from another party)

I authorize _____
(Name or description of program making the disclosure)

TO DISCLOSE/RELEASE requested information to the Tennessee Dental Wellness
Foundation to facilitate case management and advocacy efforts.

Participant's Name (Please Print)

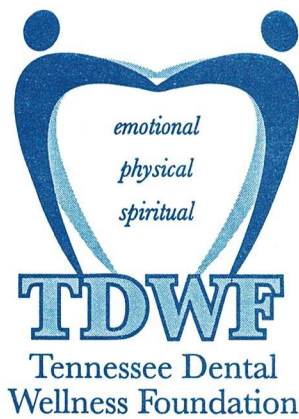
Participant's Signature

Date

This consent is subject to written revocation at any time except to the extent that the
TDADPWC, which is to make this disclosure, has already taken action in reliance on
this Authorization/ Consent.

1821 Heritage Park Plaza, Unit 3 • Murfreesboro, TN 37129 • 615-628-3200
Website: tndentalwellness.com • Email: info@tndentalwellness.com

Restoring lives to a life worth living, saving careers, and thereby serving citizens of Tennessee.



Authorization and Consent for Release of Information
(Release from the Tennessee Dental
Wellness Foundation to another party)

_____ authorize
(Participant's Name, Please Print)

The Tennessee Dental Wellness Foundation TO DISCLOSE/RELEASE copy(ies) or summary(ies) of information pertinent to Tennessee Dental Wellness Foundation participation, compliance, aftercare, along with other treatment/assessment facility's information/recommendations.

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

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

_____ (Participant's Signature) _____ (Date)

EXPIRATION: This consent is subject to written revocation at any time except to the extent that the Tennessee Dental Wellness Foundation, which is to make this disclosure, has already taken action in reliance on this Authorization/ Consent.

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