

Authorization and Consent for Release of Information

I _____ authorize
(Participant's Name, Please Print)

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

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

Address: _____

Phone: _____ Email: _____

For the purpose of: To facilitate advocacy efforts and/or aftercare follow-up.

(Participant's Signature)

(Date)



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

To disclose/release requested information to the Tennessee Dental Wellness Foundation

For the purpose of: To facilitate case management and advocacy efforts.

Phone: _____ Email: _____

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 above entity, which is to make this disclosure, has already acted in reliance on this Authorization/ Consent.

42 CFR Part 2. The information disclosed is protected by federal law and the recipient cannot make any further disclosure of the information unless permitted by the regulations.