New Hampshire DENTAL SOCIETY

PATIENT REQUEST FOR MEDIATION

Upon receipt of this completed form a mediator will be assigned and will contact you shortly to discuss your request and help resolve the issue. While a return of the charges you have paid is one of the actions that may be recommended by the mediator, a request for a refund should not be made in writing or on this form.

Patient Information:

Date:_____/_____/_____ Case # (office use only) _____

Name:_____Phone # (_____)_____

Address:_____

City:_____State:_____Zip Code:_____

Dentist Information:

Name:_____Phone # (_____)_____

Address:_____
City:_____State:_____Zip Code:_____

Date of Last Appointment _____/_____/_____

Please describe the problem (s) specific to the dental treatment received:

_____

_____

_____

_____

_____

_____

PLEASE COMPLETE REVERSE SIDE

Thank you for addressing your concerns to the New Hampshire Dental Society.

Please provide below a phone number and the best time of day when the mediator will be able to contact you. If you have any questions in the meantime, please do not hesitate to contact us at (603) 225-5961.

Day phone: (_____)_____ Time : _____

Night phone : (_____)_____ Time:_____

In order that a complete review be performed, I authorize the release to this committee, of any dental records or information by anyone who has examined me previously. I further give my permission for the committee to perform a clinical examination if necessary.

_____

Signature

New Hampshire
DENTAL SOCIETY
23 South State Street, Concord, New Hampshire 03301
Tel. (603) 225-5961 Fax: (603) 226-4880 www.nhds.org

HIPAA VALID AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Patient:
Name _____ Phone # (_____)_____ Address
_____
City_____ State _____ Zip _____

Dentist:
Name _____ Phone # (_____)_____ Address
_____
City_____ State _____ Zip _____

I, _____, am requesting mediation, peer review and/or peer review appeal relating to treatment provided to me by Dentist.

On this date: _____, I hereby authorize Dentist and all other dental and medical sources to use and disclose any and all records or information about my dental and medical history, condition, and treatment, including but not limited to my complete health record, and payment for treatment (collectively, "My Health Information"), in any form or format, including but not limited to hard copy, electronic and oral information, radiographs, and photographs, that may be relevant to treatment provided to me by Dentist, to the New Hampshire Dental Society and their employees and volunteers, 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.

Purpose for Disclosure: At the request of the individual, for purposes of mediation, peer review, and any peer review appeal.

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.

I understand that I may revoke this authorization at any time by sending written notice to: New Hampshire Dental Society, 23 South State Street, Concord, NH 03301.

I understand that this authorization remains effective until Dentist or other dental or medical source is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed. I understand that any revocation will not affect any use or disclosure permitted by the authorization while it was in effect, and that information about my right to revoke may also be in the Notice of Privacy Practices of Dentist or other dental or medical source.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits. However, if I refuse to sign or revoke this authorization, I may not be able to participate in mediation, peer review, and/or appeal.

I hereby release, hold harmless, and agree to indemnify Dentist, any other dental or medical source that I have hereby authorized to use or disclose my Health Information, New Hampshire Dental Society, and their employees, members, volunteers, contractors, and

agents, for any and all legal responsibility or liability (including but not limited to negligence) arising out of or occurring under this authorization and the use and/or disclosure of information to the extent indicated and authorized herein.
A copy of this signed, dated Authorization shall be effective as the original.
I understand that I may refuse to sign this authorization. I have been given an opportunity to ask questions, and I have received a copy of the signed authorization.
Signature of patient or patient's personal representative:
_____
Date: _____
If personal representative – Print Name: _____
Relationship to Patient: _____
_____
_____
For office use only: Copy of signed authorization provided to the individual:
Date: _____ Initials:_____