TENNESSEE DENTAL ASSOCIATION
PATIENT REQUEST FOR MEDIATION

Upon receipt of this completed form, a mediator will be assigned and will contact you to discuss your request and attempt to resolve the issue. Please state your complaint concisely on a separate page. **Note: Mediation is designed to address the complaint of dental treatment between patient and dentist only.**

Patient Information:

Date_____ **[**Case #_____ (TDA office use only)]

Name_____

Address_____

City_____ State_____ Zip_____

Please provide below a phone number and the best time of day when the mediator will be able to contact you.

Day Phone (_____)_____ Time_____

Night Phone (_____)_____ Time_____

Dentist Information: (MUST PROVIDE DENTIST'S FIRST AND LAST NAME)

Name_____ Phone number_____

Address_____

City_____ State_____ Zip_____

Date of last appointment _____

State your complaint on a separate page and attach to this form.

Please read and sign the reverse side regarding release of information.

Return completed form to:

TDA PEER REVIEW, 660 Bakers Bridge Avenue Suite 300, Franklin, TN 37067

Authorization to Use and Disclose Health Information

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Name_____

Dentist_____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below. 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.

Information to be used or disclosed: any and all information related to treatment provided to me by the above-named dentist regarding treatment as it relates to the attached complaint.

Purpose for Disclosure: mediation, peer review, and any peer review appeal.

I authorize the following person(s) to make the requested use or disclosure of the above health information: Dentist and any workforce member of Dentist's practice.

Person(s) receiving my authorized information include the Tennessee Dental Association Peer Review Committee, 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.

I understand that I may revoke this authorization at any time by sending written notice to: Tennessee Dental Association/Peer Review Committee, 660 Bakers Bridge Avenue, Suite 300, Franklin, TN 37067.

If I choose to revoke this authorization, my revocation will not affect any actions that were taken before written notice of my revocation was received. I understand that if I refuse to sign or revoke this authorization, I may not be able to participate in mediation, peer review, and/or appeal.

_____ _____

Signature of patient or patient's personal representative Date

If personal representative, print name: _____

Relationship to patient: _____