Patient Request for Mediation

CONFIDENTIAL

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

Patient Information:

Date: _____ Phone # (____)_____

Patient Name:_____

Name of Dentist: _____

Patient Address:_____

City:_____ State:_____ Zip:_____

Date of Last Appointment:_____

Please check the appropriate issue and describe the problem(s) specific to the dental treatment received. Please print or type.

____Quality of Care and/or ___ Appropriateness of Care

_____

_____

_____

_____

_____

_____

_____

_____

(Continued on page 2)

How have you tried to resolve the problem(s) with the dentist?

Thank you for addressing your concerns to the Mississippi Dental Association.

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 the Mississippi Dental Association at (601) 664-9691.

Day Phone # (___) _____ Time_____

Night Phone # (___) _____ Time_____

In order that a complete review is 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. In accordance with federal laws a signed HIPAA form must be submitted along with this mediation form.

_____
Patient Signature

HIPAA Authorization Form

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

Patient: _____ 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 Mississippi Dental Association 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:

Mississippi Dental Association
439B Katherine Drive
Jackson MS 39232-9781

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, Mississippi Dental Association, 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 understand that I will received a copy of the signed authorization.

Signature of patient or patient's personal representative:

_____

Date: _____

If personal representative
Print Name: _____

Relationship to Patient: _____

Please return completed form to:
Mississippi Dental Association
439 B Katherine Drive
Flowood, MS 39232-9781

For office use only: Copy of signed authorization provided to the individual:
Date: _____ Initials: _____