

CHATTANOOGA-HAMILTON COUNTY
HEALTH DEPARTMENT
CHATTANOOGA, TN

Place Encounter Label Here

PERMISSION FOR SERVICES

PERMISSION FOR MEDICAL SERVICES

- I do hereby give my consent for the Chattanooga-Hamilton County Health Department to perform screenings, examinations and/or provide treatments for disease, referrals to other health care practitioners and the necessary follow-up to myself, my child, or ward. I understand that I have the right to refuse any and all treatment and medications.
- Initial and Date:** _____

PERMISSION FOR DENTAL SERVICES

- I do hereby give my consent for any dental care for myself, my child, or my ward, which the examining dentist feels is necessary, including x-rays, fluoride treatments, restorations, and extractions. I also give my consent for the use of local anesthetics, nitrous oxide-oxygen mixture, and other drugs as deemed necessary by the dentist. I understand that I have the right to refuse any and all treatment and medications.
- Initial and Date:** _____

GENERAL PROVISIONS FOR RELEASE OF INFORMATION:

- I authorize the release of dental or medical information necessary and appropriate to provide care for myself, my child, or ward. I also authorize the release of medical or dental information necessary and appropriate to prevent and control communicable disease, comply with required audits, and medical record review. Furthermore, I authorize the release of medical, dental or other information necessary to process a claim to TennCare, Medicare, or any health insurance plan. I understand the Health Department is not responsible for nor does it control information contained in communications from insurance companies and that the Health Department cannot prevent such communications. This authorization will expire three (3) years after the date it is signed.
- Initial and Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- I acknowledge that I have received a copy of the Chattanooga-Hamilton County Health Department Notice of Privacy Practices.
- Initial and Date:** _____

SIGNATURE _____ **DATE** _____

RELATION TO PATIENT _____ **(complete if other than patient)**

WITNESS _____ **DATE** _____

Recorded by: (For Staff Use Only) _____