

CHATTANOOGA-HAMILTON COUNTY
HEALTH DEPARTMENT
CHATTANOOGA, TN

Place Encounter Label Here

PERMISSION FOR SERVICES

PERMISSION FOR HEALTH SERVICES

- I, the undersigned, 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. I also acknowledge the release of medical 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 or other information necessary to process a claim to TennCare, Medicare, or any health insurance plan. This authorization will expire three (3) years after the date it is signed.

- Initial and date _____

PERMISSION FOR DENTAL SERVICES

- I, the undersigned, 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. I also authorize the release of dental information necessary and appropriate to provide care for myself, my child, or ward. Furthermore, I acknowledge the release of any dental, medical, or other information necessary to process a claim to TennCare, Medicare, or any health insurance company. 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) _____