

MEDIATION RELEASE

Date: \_\_\_\_\_

Michael Kubelka, DDS, Chair  
Standing Committee on Mediation Review  
317 NE 13<sup>th</sup> St.  
Oklahoma City, OK 73104

Dear Dr. Kubelka,

So that my review can be as complete as possible, I hereby authorize the District Dental Society Mediation Review Committee assigned to my case and the Standing Committee on Mediation Review to review any information related to the examination and treatment by Dr. \_\_\_\_\_ . I also hereby authorize the committee to review any additional information submitted by me involving dental or medical services rendered to my minor child or me by any dentist or physician. I understand that obtaining records, written statements or testimony from any health practitioner other than Dr. \_\_\_\_\_ is my responsibility. I also give my permission for the Mediation Review Committee members to perform a dental examination on me or my minor child \_\_\_\_\_ .

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**NOTE: Patient should make additional copies of this release before returning to the ODA if planning to request medical records from other physicians.**

**PATIENT REQUEST FOR MEDIATION**

Upon receipt of this completed form, a mediator will be assigned and will contact you within two weeks to discuss your request and help resolve the issue. Please complete the form and briefly describe the problem(s) specific to the dental treatment received. The mediator will be in touch with you shortly.

Date: \_\_\_\_\_ Who referred you to mediation? \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (Daytime): \_\_\_\_\_ (Evening): \_\_\_\_\_

Please indicate the best time of day when the mediator can contact you: \_\_\_\_\_

**Dentist Name:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**Date dental treatment in question was done:** \_\_\_\_\_

**Please briefly describe the problem(s) specific to the dental treatment received:** (Attach additional pages as needed)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please complete and sign both forms and return to:**

Oklahoma Dental Association  
Mediation Review  
317 NE 13<sup>th</sup> St.  
Oklahoma City, OK 73104