NOTICE OF PRIVACY PRACTICES

This NOTICE describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully. KEEP FOR YOUR RECORDS.

OUR LEGAL DUTY
We remind you that federal and state law require that we maintain the privacy of your health information. We will not sell, rent, or otherwise disclose your health information to others except as described in this Notice. This Notice applies to all of the related agencies that maintain the privacy of your health information. Unless you give us written permission to do so, your information may not be used or disclosed for purposes other than treatment, payment, or healthcare operations.

We reserve the right to change our privacy practices and the terms of our Notice at any time, provided such changes are permitted by law. We reserve the right to make the new Notice effective for all health information that we maintain after the date of the change. In that case, we will provide you with a copy of the revised Notice on or before the effective date. If you have any questions about this Notice, please call our Contact Officer.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician, school nurse, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our business operations such as receiving the compensation or qualifications of healthcare professionals and evaluating practitioner and provider performance.

Your Authorization: Use or disclosure not otherwise permitted by this Notice requires your written authorization. The notice of revocation of authorization will be sent to your designated representative.

Your rights and responsibilities are described in more detail below.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

PATIENT RIGHTS

Treatment: We may not use or disclose your health information to a physician, school nurse, or other healthcare provider providing treatment to you.

Payment and Health Care Operations: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information for the following purposes:

- To obtain payment for the treatment you receive from us.
- To conduct quality assessment activities.
- To conduct peer review activities.
- To conduct or arrange for other healthcare operations activities such as training health care providers in professional competency.

When we use or disclose your information, we will do so in a manner that provides you access to your health information. However, we may disclose summary information about your health, but not your personal health information, in a variety of situations. For example:

- To our healthcare workers, such as school nurses.
- To the Department of Education.

You have certain rights with respect to your health information. A description of each of these rights is provided below.

To Your Friends and Family Members: In Your Care: We may disclose your health information to a family member, friend, or other person involved in your care.

Restriction: You may request a restriction of your health information that is to be used or disclosed only for treatment, payment, or healthcare operations.

Restriction: You have the right to restrict disclosures of your health information to a family member or friend, or other person involved in your care.

Alternative Communication: You have the right to receive the notice that we communicate with you about your health information by alternative means or to alternative locations specified in your written request.

Amendment: If you amend your health information, your request must be in writing and must explain why the information should be amended.

To the extent that we have already made disclosures that were subject to an amendment request, we will comply with the amendment request on or before the effective date. If you have any questions about this Notice, please call our Contact Officer.

Electro-Questionnaire:

1. You have the right to know if we have received this Notice and to be informed of our obligations to maintain the confidentiality of your information.

2. You have the right to receive a copy of this Notice at any time.

QUESTIONS AND COMPLAINTS

If you believe your privacy rights have been violated, you can file a complaint with the school's data officer or by mail. You can also file a complaint with the school's data officer or by mail.

HIPAA COMPLIANCE PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release the information as specified.

Signature of Parent/Guardian (or student if 18 years or older or otherwise permitted by law) ____________________________ Date ____________

Please be sure to review both sides of this consent.
Patient’s Bill of Rights

As a patient of Smile New York Outreach, you have the right to:

1. Understand and use these rights. If for any reason you do not understand or you need help, the Center must provide assistance, including an interpreter.
2. Receive services without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or source of payment.
3. Be treated with consideration, respect and dignity including privacy in treatment.
4. Be informed of the services available at the Center.
5. Be informed of the provisions of off-hour dental emergency coverage.
6. Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care.
7. Receive an itemized copy of his/her account statement, upon request.
8. Obtain from his/her health care practitioner, or the health care practitioner’s delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand.
9. Receive from his/her dentist information necessary to give informed consent prior to the start of any non-emergent procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the risks involved, and alternatives for care or treatment, if any.
10. Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action.
11. Refuse to participate in experimental research.
12. Express complaints about the care and services provided and to have the Center investigate such complaints, without fear of reprisal. A patient may express their concern verbally or in writing to the administrator. The Center is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The Center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the Center’s response, the patient may complain to the New York State Department of Health’s Office of Health Systems Management by calling 1-800-804-5447.
13. Privacy and confidentiality of all information and records pertaining to the patient’s treatment.
14. Approve or refuse the release or disclosure of the contents of his/her dental record to any healthcare practitioner and/or healthcare facility except as required by law or third-party payment contract.