



Consent Form

Dear Parents/Guardians, for us to provide services to your child you must complete this consent form.

School: _____ Teacher: _____ Grade: _____

Child's Name: _____ **DOB:** _____ **Gender** M F

Parent Name: _____ Language spoken at home: _____

Home address: _____ City/: _____ Zip Code: _____

Phone: (H) _____ (W) _____ (Cell) _____

Emergency contact person:

Name: _____ Relationship (to child): _____

Phone: (H) _____ (Cell): _____

No, I do not want my child to participate in the program at this time.

Signature of Parent or Guardian _____ Date: _____

Yes, I want my child to receive dental education, screening, dental cleaning, fluoride treatment, sealants, intraoral images and a parent report.

Yes, I want a copy of my child's Student Oral Health Report to be given to the school nurse. It will include the same information as the Dental Health Certificate requested by the school.

Insurance Information

Medicaid, Fidelis, MVP, CDPHP, CHP

ID/CIN # _____

Group # _____

Child's Name on Card _____

My child has no health insurance at this time.

**Uninsured children can receive full services at no cost if you make arrangements at 462-7049.*

We must have the information on the back completed to serve your child.



Seal a Smile School Based Oral Health Program
A project of Whitney M. Young Jr. Health Services and Healthy Capital District



***Student's Name** _____ **DOB:** _____ *

Has your child ever had any of the following? **Please check Yes or No.**

	YES	NO		YES	NO
Heart Disease			Asthma		
Heart Murmurs			Tuberculosis		
Rheumatic Fever			Hemophilia/Bleeding disorder		
Kidney Disease			Seizure disorder		
Anemia			Hearing loss		
Diabetes			Vision problems		
Hepatitis/Liver Disease			Serious injuries		
Autism Spectrum			Artificial joints		
Operations/Hospitalizations			Other Health Issues:		
Does your child take medications? Please list medications: (Attach list if necessary.)			Allergies: (Please list)		

Does your child (please circle): Drink fluoridated water? Receive daily fluoride supplement/vitamin?

Does your child have a dentist? **Yes / No**

Dentist Name: _____ Address: _____ Phone: _____

Physician name _____ Address: _____ Phone: _____

****I give permission for my child to participate in the Seal a Smile School Based Dental Program. I also give permission for Seal a Smile staff to exchange information about my child's oral health, health insurance and parent/guardian contact information with my child's dentist, doctor and school district. If my child has health and/or dental insurance, I have provided the Medicaid or CHP number. I also acknowledge that I have received a copy of the HIPAA/Notice of Privacy Practices which can be found on the last two pages of this consent form.***

Signature of Parent or Guardian: _____ Date: _____

Print Name of Parent or Guardian: _____ Date: _____

Please send me a survey to provide comments or suggestions to how Seal a Smile School Based Dental Services can best serve your school. **Yes / No**

Please place this form in the envelope provided and return it to school. Thank you!

(Office Use)

<i>Services: Please Circle</i> SCR PRO OHI FL SL 3-14-19-30-2-15-18-31	<i>Consent & Health hx reviewed and services provided by:</i> _____ RDH, _____ date _____ RDH, _____ date _____ RDH, _____ date
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Whitney M. Young, Jr. Health Center, Inc.

NOTICE OF PATIENT PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), The Health Information Technology for Economic and Clinical Health of 2009 (HITECH) and the Omnibus Rule of 2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU MAY ACCESS YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Whitney M. Young, Jr. Health Center (WMY) is dedicated to maintaining the privacy of your “Protected Health Information” (PHI). PHI is any individual identifiable health information we create or receive that relates to your past, present or future health care or medical condition. PHI includes paper, electronic and oral data.

We are required by law to maintain the confidentiality of PHI. We also are required to provide you with this notice of our legal duties and the privacy practices that we maintain concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Our practice will post the current Notice of Privacy Practices on our Website at www.wmyhealth.org, and you may request a copy of our Notice at any time.

B. WMY MAY USE AND DISCLOSE YOUR PHI IN THE FOLLOWING WAYS

- 1. Treatment.** Our practice may use your PHI to provide, coordinate and manage your health care. We may disclose medical information about you to other doctors, nurses, technicians, clinical laboratories, imaging companies, or other personnel in an unrelated organization for purposes related to your treatment including care coordination. For example, we may refer you to a specialist and share your PHI with that provider. Or we might disclose your PHI to a pharmacy when we order a prescription for you.
 - 2. Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. We may use your PHI to bill you directly for services and items.
 - 3. Health Care Operations.** Our practice may use and disclose your PHI to operate our business. For example our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
 - 4. Business Associate.** We may disclose information to a person or entity we contract with to perform some of our business functions-for example, a billing service or attorney. Business associates and sub-contractors are held to the applicable provision of HIPAA standards.
 - 5. Appointment Reminders and Treatment Options.** Our practice may use and disclose your PHI to contact you and remind you of an appointment in a generic manner and to inform you of potential treatment options or alternatives.
 - 6. Family/Friends.** Our practice may release directly relevant PHI to a family member or friend that is involved in your care, helps pay for your care or who assists in taking care of you, unless you provide written instructions not to. Similarly, after your death, relevant disclosures may be made to these same people. HIPAA protection is eliminated 50 years after a patient’s death.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority for you before we take any action.
- 7. Disclosures Required By Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.
 - 8. Alcohol and Substance Abuse, Mental Health and HIV PHI.** Disclosure of information related to Alcohol and Substance Abuse, Mental Health and HIV treatment is further protected in by Federal Regulation 42 CFR. Specific authorization for release of these treatment records is required. WMY uses NYS DOH for 5032 for appropriate authorization to release these treatment records.



C. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

- 1. Childhood Immunizations.** WMY may disclose immunizations to schools required to obtain proof of immunizations prior to admitting the student as long as we have and document in the EMR the parent's or legal guardian informal agreement to the disclosure.
- 2. Public Health Risks.** WMY may disclose your PHI for public health activities and purposes. For example, we may disclose information to a public health authority that is authorized to receive such information for the purpose of controlling disease, injury or disability. WMY may also disclose your PHI to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law or rule permits us to do so.
- 3. Abuse or Neglect.** We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, if we believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your PHI to the governmental entity or agency authorized to receive such information.
- 4. Health Oversight Activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
- 5. Lawsuits and Similar Proceedings.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.
- 6. Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:
 - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement;
 - Concerning a death we believe has resulted from criminal conduct;
 - Regarding criminal conduct at our offices;
 - In response to a warrant, summons, court order, subpoena or similar legal process;
 - To identify/locate a suspect, material witness, fugitive or missing person; or
 - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).
- 7. Research.** We may disclose your PHI to researchers if an institutional review board reviews and approves the research proposal and protocols to ensure your privacy.
- 8. Serious Threats to Health or Safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
- 9. Specialized Governmental Functions.** Our practice may use or disclose PHI for specialized governmental functions, such as disclosing information about a member of the armed services to the military to assure the proper execution of a military mission, or disclosing information about inmates to a correctional facility for security, continued health care or safety or other important purposes.
- 10. Workers' Compensation.** Our practice may release your PHI for workers' compensation and similar programs.
- 11. Marketing Communications.** WMY must obtain your written authorization to market a third party's product or service to you except when:
 - WMY receives no compensation for marketing the third party's product or service;
 - The communication is face to face;
 - The communication involves a drug or biologic that you are currently being prescribed and the payment is limited to reasonable reimbursement of the cost of the communication (no profit);
 - The communication involves general health promotion, rather than the promotion of a specific product or service; or
 - The communication involves government or government sponsored programs.
- 12. Sale of PHI.** WMY will not sell your data to an outside entity, nor will we permit an outside entity to access your information for purposes of informing you of health-related benefits or services without your explicit written authorization.
- 13. Fundraising.** Our practice may use demographic data, dates of service, department of service, treating provider, outcome information and health insurance information to send you material in connection with our efforts to raise funds. If we do, we will have a clear and conspicuous method to let you know how to opt out of receiving any future fundraising materials.



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*20th Anniversary
School Year*

D. YOUR RIGHTS REGARDING YOUR PHI

Although your health records are the physical property of WMY and the health care providers who created it, you have the following rights with regard to the information contained therein and the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to WMY specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict disclosure of your PHI to individuals involved in your care or the payment for your care, such as family members and friends. You must provide us with a written request which states the specific restriction requested and to whom you want the restriction to apply. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

Also, if you pay for a service or health care item in full, you may ask us not to share the information for the purpose of payment or our operations with your health insurance. We will honor your request unless required by law. This restriction request must be in writing.

3. Inspection and Copies. You have the right to inspect and obtain an electronic or paper copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to WMY. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.

4. Amendment. You may ask us to correct your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. You must provide us with written request and a reason that supports your request for amendment. Our practice may deny your request to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. You have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. All requests for an “accounting of disclosures” must be in writing, state a time period, which may not be longer than six (6) years from the date of disclosure. We’ll provide one accounting a year for free but will charge a reasonable, cost based fee if you ask for another one within 12 months.

6. Notice of Breach. You have the right to receive a written notice of a breach of your unsecured PHI by first class mail or by secured email if that is your recorded preference. WMY will send the notice without unreasonable delay and within 60 days of the discovery of the breach.

7. Right to a Copy of This Privacy Notice. You are entitled to receive a paper copy of our notice of privacy practices at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly..

8. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice by calling **the Corporate Compliance Officer** at 1-518-591-4905 or sending a letter to the address below. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington D. C.20201, calling 1-877-696-6775, or visiting www.hhs.gov/orc/privacy/hipaa/complaints/... **You will not be penalized or retaliated against for filing a complaint.**

9. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Corporate Compliance Officer

920 Lark Drive, Albany, NY 12207

518-591-4905

It is the policy of WMY that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.