USE AND DISCLOSURE OF HEALTH INFORMATION

When you visit the XXXXX program, your health information may be used as follows:

-Documented treatment services may be shared with other healthcare providers involved in meeting a student's oral health needs.

-To communicate with family members involved in meeting the student's oral health care needs.

-To conduct normal business practices and management of the SEAL program.

-To provide payment/billing information about services provided by SEAL to third parties in order to receive payment.

-To communicate appointment reminders by telephone or mail.

There are limited times when the XXXXX program is permitted or required to disclose health information without your signed permission These situations could include but are not limited to:

-For Public Health activities such as tracking diseases or medical data.

-To protect victims of abuse or neglect.

-For federal or state health oversight activities such as fraud investigations. When required to do so by Federal, State or local law.

Other uses and disclosures not previously described may only be done with your signed authorization. You may revoke your authorization in writing at any time.

HOW TO CONTACT US

If you have questions or would like further information about this notice, please contact:

YOUR NAME

CONTACT INFORMATION

INSERT LOGO OR PICTURE HERE

ORAL HEALTH PREVENTION PROGRAM

YOUR NAME AND NAME OF PROGRAM

NOTICE OF PRIVACY PRACTICES
Effective: ENTER DATE

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice applies to all staff covered under this program.

PATIENT PRIVACY PLEDGE

At the XXXXX program, the privacy of the individual participating is a priority. We understand that health information is personal and we are committed to protecting their health information. We will follow strict federal and state guidelines to maintain the confidentiality of all health information and will follow the terms of this notice.

Our Responsibilities:

Ensure that identifying health information about you is kept private

Provide notice of our legal duties and privacy practices with respect to health information

Communicate any changes made to current privacy practices.

Your Rights:

Request that we restrict how we use or disclose your health information

Request use of specific telephone number or address to communicate with you.

Inspect and copy your health information (fees may apply)

Receive an accounting of how your health information was disclosed

Obtain a paper or electronic copy of this notice

Register a complaint: see File a Complaint.

FILE A COMPLAINT

If you believe your privacy rights have been violated, you may file a complaint the Secretary of the Department of Health and Human Services:

Office of Civil Rights,
United States Department of Health and Human Services

Government Center
JFK Federal Building 1875
Boston , MA 02203
(617) 565-1340 or
TDD (617) 565-1348

No action may be taken against you for filing a complaint.