WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
		High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

NEW YORK UNIVERSITY COLLEGE OF DENTISTRY
NOTICE OF PRIVACY PRACTICES
Effective Date: April 14, 2003; Revised as of September 6, 2016

Patient's Name_____DOB_____Date_____

THIS NOTICE OF PRIVACY PRACTICES ("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.

WHY ARE YOU GETTING THIS NOTICE?
The New York University College of Dentistry is required by law to protect the privacy of your health information. We are also required to provide you with a copy of this Notice. It describes the health information privacy practices of our institution, dental faculty, students, staff and affiliated health care providers who work together to provide health care services at the College of Dentistry and its facilities.

If you have questions about this Notice or would like further information, please contact our Privacy Officer at (212) 998-9777.

We will ask you to sign an "acknowledgment" indicating that you have been provided with this Notice.

WHO FOLLOWS THE POLICIES IN THIS NOTICE?
The privacy practices described in this Notice are followed by:

- Any health care professional who treats you at any of our dental clinics and faculty practice offices (i.e. the Dental Center, Faculty Practice North, Faculty Practice South, and Oral Surgery Faculty Practice in Bluestone Center for Clinical Research Dental Center, Faculty Practice North, Faculty Practice South, and Oral Surgery Faculty Practice in Bluestone Center for Clinical Research), collectively referred to as the "*College of Dentistry facilities*".
- All employees, students, trainees, or volunteers providing services at any of our *College of Dentistry facilities,* including our dental clinics and faculty practice offices.
- Any business associates of the *College of Dentistry facilities* (See Paragraph I-1f, for a description of business associates.)

WHAT HEALTH INFORMATION IS PROTECTED?
We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- Information indicating that you are a patient of the *College of Dentistry facilities* or that you are receiving treatment or other health-related services from any health care professional at any of our *College of Dentistry facilities*;
- Information about your health condition (such as a disease you may have);
- Information about health care products or services you have received or may receive in the future; or
- Information about your health care benefits under an insurance plan (such as whether a particular dental procedure or service is covered);

- *When combined with*:

- Demographic information (such as your name, address, or insurance status);
- Unique numbers that may identify you (such as your chart number, social security number, your phone number, or your driver's license number); and
- Other types of information that may identify who you are.

I. HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

The College of Dentistry facilities may use or disclosure your health information for the purposes of treatment, payment and health care operations. Your health information may be used or disclosed without your written authorization for these purposes. The College of Dentistry facilities have established a policy to guard against unnecessary uses and disclosures of your health information. The purposes for which your health information may be used and disclosed by the College of Dentistry facilities are summarized as follows:

1) Treatment, Payment, and Health Care Operations
We may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run our health care operations.

a. **Treatment:** We may share your health information with dental faculty, students, staff or other allied health care professionals at the College of Dentistry facilities who are involved in taking care of you. They may, in turn, use that information to diagnose or treat you. A dentist or other health care professional at the College of Dentistry facilities may share your health information with another doctor inside our facility, or with a doctor at another hospital, to determine how to diagnose or treat you. We may also share your health information with other health care providers who referred you to us and/or to whom you have been referred for further health care.

b. **Payment:** We may use your health information or share it with others so that we may obtain payment for your health care services. For example, we may share information about you with your health insurance company. This will help us obtain reimbursement after we have treated you, or determine whether your health insurance will cover your treatment. We might also need to inform your health insurance company about your health and dental condition in order to obtain pre-approval for your treatment. Finally, we may share your information with other health care providers and payers for their payment activities. We may ask for your consent to use or disclose your health information for some or all of these payment activities.

c. **Health Care Operations:** We may use your health information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the performance of our dental faculty, students, staff or other allied health care professionals at the College of Dentistry facilities who are involved in taking care of you. We may also share your health information with other health care providers to help them with their business operations.

d. **Appointment Reminders, Treatment Alternatives, or Distribution of Health-Related Benefits and Services:** In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment or services at our facility. We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services, such as health promotion activities, disease awareness or case management that may be of interest to you. However, to the extent a third party provides financial remuneration to us so that we make these treatment or healthcare operations related communications to you, we will secure your authorization in advance as we would with any other marketing communication (as described later in this Notice).

e. **Fundraising:** To support our business operations, we may use demographic information about you in order to contact you to raise money to help us operate. Examples of demographic information include information about your age and gender, and where you live or work. However, you have the right to opt-out of future communications and can do so by following the opt-out instructions provided as part of the fundraising communication. Fundraising is a communication from the College of Dentistry facilities or one of its business associates for the purpose of raising funds for the College of Dentistry facilities, including appeals for money or sponsorship of events.

f. **Business Associates:** We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company. Another example is that we may share your health information with an accounting firm or law firm that provides professional advice. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.

2) **Families and Friends Involved in Your Care:** If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for that care. We may also notify a family member, personal representative, or another person responsible for your care about your location and general condition here at the College of Dentistry facilities. In some cases, we may need to share your information with a disaster relief organization that will help us notify these persons.

3) **Research:** In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may use and disclose your health information without your written authorization. To do this, we are required to obtain approval through a special process to ensure that research without your written authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your written authorization to people who are preparing a future research project, so long as any information identifying you does not leave our facility. In the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

4) **Completely De-identified or Partially De-identified Information:** We may use and disclose your health information if we have removed any information that has the potential to identify you, so that the health information is "completely de-

identified." We may also use and disclose "partially de-identified" health information about you for certain purposes if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will *not* contain any information that would directly identify you (such as your name, street address, chart number, social security number, phone number, fax number, electronic mail address, website address, or license number).

5) **Incidental Disclosures:** While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

6) **Public Need**

a. Emergencies: We may use or disclose your health information if you need an emergency treatment or if we are required by law to treat you but are unable to obtain your written consent. If this happens, we will try to obtain your written consent as soon as we reasonably can after we treat you.

b. As Required By Law: We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

c. Public Health Activities: We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials who are responsible for controlling disease, injury, or disability. We may also disclose your health information 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 permits us to do so.

d. Victims of Abuse, Neglect, or Domestic Violence: We may release your health information to a public health authority or other authorized governmental authority if we reasonably believe you have been a victim of abuse, neglect, or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

e. Health Oversight Activities: We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

f. Product Monitoring, Repair, and Recall: We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

g. Lawsuits and Disputes: We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.

h. Law Enforcement: We may disclose your health information to law enforcement officials for the following reasons:

- To comply with court orders or laws that we are required to follow;
- To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
- If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your agreement because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
- If we suspect that your death resulted from criminal conduct;
- If necessary to report a crime that occurred on our property; or
- If necessary to report a crime discovered during an offsite medical emergency.

i. To Avert A Serious And Imminent Threat to Health or Safety: We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers: 1) if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that

fact while in counseling), or 2) if we determine that you escaped from lawful custody (such as a prison or mental health institution).

j. National Security and Intelligence Activities or Protective Services: We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

k. Military and Veterans: If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

l. Inmates and Correctional Institutions: If you are an inmate, or if a law enforcement officer detains you, we may disclose your health information to the prison officers or law enforcement officers. This may happen if it is necessary to provide you with health care, or to maintain safety, security, and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

7) Workers' Compensation: We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

8) Coroners, Medical Examiners, and Funeral Directors: In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

9) Organ and Tissue Donation: In the unfortunate event of your death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

10) Marketing: We may not disclose your health information or share it with others outside the College of Dentistry facilities for purposes of marketing without your prior authorization. Marketing is a communication about a product or service that encourages recipients of the communication to purchase or use the product or service. However, we may inform you about products or services during face-to-face communications with you without your authorization, including providing related written materials to you. We may also, without your authorization, provide to you promotional gifts of nominal value that may encourage you to purchase or use a product or service.

II. USES AND DISCLOSURES OF YOUR HEALTH INFORMATION REQUIRING AUTHORIZATION

Other than as stated above, the College of Dentistry facilities will not use or disclose your health information without your written authorization. We will obtain your written authorization to use or disclose your health information for marketing purposes, for the sale of health information, or with respect to psychotherapy notes, except for limited health care operations purposes.

If you provide us with written authorization, you may revoke, or cancel, it at any time, except to the extent that we have already relied upon it. If you revoke the authorization, we will no longer use or disclose your health information for the reasons covered by your written authorization. Your revocation will not affect any uses or disclosures we have already made prior to the date we receive notice of the revocation. To revoke a written authorization, please write to the Privacy Coordinator or the Patient Health Information Resource Room at the College of Dentistry, or if you are a patient at one of our Faculty Practice treatment locations, please write to the respective Privacy Coordinator of that practice.

You may request that we transfer your records to another person or organization by completing a written authorization form. This form will specify what information is being released, to whom, and for what purpose. The authorization may have an expiration date.

III. SPECIAL PROTECTIONS FOR CERTAIN TYPES OF INFORMATION

The following kinds of health information are considered so sensitive that state or federal laws provide special protections for them: information about HIV testing or test results, information about substance abuse rehabilitation treatment, and information about mental health treatment or status. We may be required to, and will when required, obtain your written authorization before we can use or disclose these types of information to the government, in some instances in which we could use or disclose other types of information without your written authorization, as described in this Notice. *If you have questions about the ways that these types of information can be used or disclosed, please contact the College of Dentistry's Patient Health Information Resource Room Records or designee(s), or the respective Privacy Coordinator at College of Dentistry facilities, or speak with your licensed healthcare provider.*

IV. YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information we have about you is accurate. They may also help you control the way we use your information and share it with others, or the way we communicate with you about dental or health issues.

1) **Your Right to Request Alternative Communications**: You may request that we communicate with you by alternative means or at alternative locations. For example, you may wish to receive communications at your work location rather than your home. To request alternative communications, please contact your dentist's office. We will not ask you for the reason for your request, and will try to accommodate all reasonable requests. Please specify in your request how or where you wish to be contacted, and how payment for your health care is handled if we communicate with you through this alternative method or location. To make a request from more than one College of Dentistry facilities, please submit your request directly to the College of Dentistry's Patient Health Information Resource Room or designee, and/ or to the respective Privacy Coordinator at College of Dentistry facilities.

2) **Your Right To Inspect and Obtain Copies of Your Records:** You have the right to inspect and obtain a copy from us in a timely manner of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes dental and billing records.

   a. **How to Make Your Request:** To inspect or obtain a copy of your health information, please submit your request in writing to the respective Privacy Coordinator at College of Dentistry facility in which you are or have been treated. To make a request from more than one College of Dentistry facilities, please submit your request directly to the College of Dentistry's Patient Health Information Resource Room or designee, and/ or to the respective Privacy Coordinator at College of Dentistry facilities. A request to inspect or obtain a copy of your health information must include: (1) the desired form or format of access; (2) a description of the health information to which the request applies; and (3) appropriate contact information.

   b. **Cost:** If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request.

   c. **Form and Format:** If the information you request is stored electronically, we will provide the information in the form and format you request if the information is readily producible in that format, or, if not, we will reach an agreement with you as to alternative readable electronic format.

   d. **Response Time:** We will respond to your request for inspection of records within 10 days. We ordinarily will respond to requests for copies within 30 days if the information is located in our facility and within 60 days if it is located off-site at another facility. If we need additional time to respond to a request for copies, we will notify you in writing within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request.

   e. **If Your Request Is Denied:** Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a summary of the information instead. We will also provide a written notice that explains our reasons for providing only a summary and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy.

3) **Your Right To Amend Records:** If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records.

   a. **How to Make Your Request:** To request an amendment, please write to your dentist's office**.** Your request should include the reasons why you think we should make the amendment. To make a request from more than one College of Dentistry facilities, please submit your request directly to the College of Dentistry's Patient Health Information Resource Room or designee, and/ or to the respective Privacy Coordinator at College of Dentistry facilities. A request to amend your health information must include a description of the amendment requested and should include the reasons why you think we should make the amendment.

b. Response Time: Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

c. If Your Request Is Denied: Your request for an amendment may be denied if you request an amendment of health information that the we determine: (1) was not created by the College of Dentistry facilities, unless the originator of the health information is no longer available to make the amendment; (2) is not part of the College of Dentistry facilities' records; (3) is not health information that you would be permitted to inspect or copy; or (4) is accurate and complete.

If we deny part or your entire request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement, which we will include in your records. We will also include information on how to file a complaint with the College of Dentistry or with the Secretary of the Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

4) Your Right To An Accounting Of Disclosures: You have a right to request an "accounting of disclosures" of your health information, which identifies other persons or organizations to whom we have disclosed your health information in the previous six years in accordance with applicable law and this Notice.

An accounting of disclosures will not include the following disclosures:

- Disclosures for treatment, payment and business operations;
- Disclosures to you or your personal representative;
- Disclosures we made pursuant to your written authorization;
- Disclosures made to your friends and family involved in your care or payment for your care;
- Disclosures that were incidental to permissible uses and disclosures of your health information;
- Disclosures for purposes of research, public health or our business operations of limited portions of your health information that do not directly identify you;
- Disclosures for national security or intelligence purposes; and
- Disclosures about inmates to correctional institutions or law enforcement officials.

a. How to Make Your Request: To request an accounting of disclosures, please write to the College of Dentistry's or Patient Health Information Resource Room or designee, and/ or to the respective Privacy Coordinator at College of Dentistry facilities. Your request must state a time period within the past six years for the disclosures you want us to include. You have a right to receive one accounting within every 12-month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12-month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred. The scope of your right to request an accounting may be modified by changes in federal law from time to time. To make a request from more than one College of Dentistry facilities, please submit your request directly to the College of Dentistry's Patient Health Information Resource Room or designee, and/ or to the respective Privacy Coordinator at College of Dentistry facilities.

b. Response Time: Ordinarily we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting. In rare cases, we may have to delay providing you with the accounting without notifying you because a law enforcement official or government agency has asked us to do so.

5) Your Right To Request Additional Privacy Protections, Including Restriction on Disclosures to Health Plans: You have the right to request that we further restrict the way we use and disclose your health information for treatment, payment or business operations. You may also request that the College of Dentistry facilities limit how we disclose information about you to family or friends involved in your care. For example, you could request that we not disclose information about a dental procedure you had. You have the right to restrict certain disclosures of protected health information to a health plan where you pay, or another person on your behalf pays, out of pocket in full for the health care item or service.

a. How to Make Your Request: To request restrictions, please write to the College of Dentistry's Patient Health Information Resource Room or designee, and/ or to the respective Privacy Coordinator at College of Dentistry facilities. The request should include what information you want to limit; whether you want the College of Dentistry to limit our use of the information, how we share it with others, or both; and to whom the limits apply. To make a request from more than one College of Dentistry facilities, please submit your request directly to the College of

Dentistry's Patient Health Information Resource Room or designee, and/ or to the respective Privacy Coordinator at College of Dentistry facilities.

b. We are Not Always Required to Agree: The College of Dentistry facilities are not always required to agree to your request for a restriction. In some cases the restriction you request may not be permitted under law. We do not need to agree to the restriction unless (i) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (ii) the health information relates only to a health care item or service that you or someone on your behalf has paid for out of pocket and in full. *However, if the College of Dentistry* facilities *do agree to the restriction, we will be bound by the agreement unless the information is needed to provide you with emergency treatment or comply with the law.* Once the College of Dentistry facilities have agreed to a restriction, you may revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction.

6) Other Obligations of the College of Dentistry Facilities: In addition to the other obligations set forth in this Notice, College of Dentistry facilities are required to:

- maintain the privacy and security of your health information in a manner consistent with HIPAA and the Privacy and Security Rules,
- provide you with this Notice of the College of Dentistry's legal duties and privacy practices with respect to your health information,
- abide by the terms of this Notice, and
- notify you if there is a breach of your unsecured health information.

7) Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the United States Department of Health and Human Services. To file a complaint with the New York University College of Dentistry, please contact our Privacy Officer at (212) 998-9777. No one will retaliate or take action against you for filing a complaint.

8) Changes to Our Privacy Practices: We may change our privacy practices from time to time. If we do, we will revise this Notice, which will apply to all health information. We will post any revised Notice at the College of Dentistry. You may also obtain a copy of the revised Notice by contacting any Privacy Coordinator at the College of Dentistry or by visiting the New York University College of Dentistry's website at www.nyu.edu/dental.

If you have not already received one, you also have the right to a paper copy of this Notice. You may also obtain a copy of the revised Notice by contacting any Privacy Coordinator at the College of Dentistry or by visiting the New York University College of Dentistry's website at www.nyu.edu/dental.

9) Contact Information: If you have any questions about this Notice, please write to Privacy Officer at *New York University College of Dentistry, 345 East 24th Street, New York, NY. 10010.*

Signature of patient, parent, or guardian	**Name of patient, parent, or guardian**	**Relationship to Patient**	**Date**