SARANAC LAKE VOLUNTARY HEALTH ASSOCIATION, INC.
NOTICE OF PRIVACY PRACTICES FOR
DENTAL EXPENSE ASSISTANCE APPLICANTS
EFFECTIVE DATE—JUNE 10, 2010

MEDICAL INFORMATION NOTICE

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. We understand that information about your health is personal and our policies require that it be kept in strict confidence.

MEDICAL INFORMATION:

Individuals applying for financial assistance for dental expenses have personal and/or dental record information gathered on admission. This includes, name, address, date of birth, dental health information, any dental insurance information.

YOUR HEALTH INFORMATION RIGHTS:

You have the right to the current Notice of Privacy Practices upon request.
Right to inspect and copy material information about you.
Right to correct information.
Right to restrict information given to individuals involved in your care.
Right to confidential communications.

HOW YOUR MEDICAL INFORMATION MAY BE USED:

Treatment information about you may be disclosed to dentists, dental office personnel or other health practitioners who may be providing services that are part of your care.

PUBLIC HEALTH:

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

PERSONAL REPRESENTATIVE:

We may use or disclose information to your personal representative (person legally responsible for your care and authorized to act on your behalf in making decisions related to your health.)

TO AVERT A SERIOUS THREAT TO HEALTH/SAFETY:

We may disclose information when there is a serious threat to your safety or that of another person. This may include cases of abuse or neglect.

COMMUNICATION WITH FAMILY:

Unless you object, health professionals, using their best judgment, may disclose to a family member or close personal friend, health information relevant to that person's involvement in care.

DISASTER/EMERGENCY SITUATIONS:

Unless you object, we may disclose health information about you to an organization assisting in relief effort.

OTHER USED OF MEDICAL INFORMATION:

Medical information about you not covered in this notice will be made only with your written permission, which you may revoke at any time.

CHANGES TO THIS NOTICE:

Changes or revisions may be made and patients will be given copies with the new effective date.

QUESTIONS:

Contact SLVHA, INC. at 891-0910, Brenda Reeve, Executive Secretary.

COMPLAINTS:

If you believe your privacy rights have been violated submit your complaint in writing to:

President of the Board, SLVHA, INC.
75 Main Street – Suite 2
Saranac Lake, New York 12983

Or

Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Jaavitz, Federal Building
25 Federal Plaza-----Suite 3312
New York, New York 10278

FINANCIAL INFORMATION NOTICE

This notice describes how financial information about you may be used and disclosed and how you can get access to this information. We understand that information about your finances is personal and our policies require that it be kept in strict confidence.

INFORMATION WE COLLECT:

Individuals applying for financial assistance for dental expenses disclose to us personal and/or financial information upon application. This includes, name, address, date of birth, income and expenses.

DISCLOSURE OF INFORMATION:

We do not disclose personal financial information about our applicants to third parties except as required by or permitted by law.

In the course of reviewing your application for dental expense financial assistance, we may disclose personal financial information about you to professionals directly involved in your dental care.

This receipt to be filed with individual's application for assistance.

I have been presented with a copy of the Notice of Dental Expense Assistance Applicants Privacy Practices detailing how my health and/or personal financial information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed_____ Date_____

Relationship (if not signed by patient) _____

I wish to place the following restrictions on disclosure of my health information: _____

_____

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INTERNAL USE ONLY:

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient/representative and sign below.

Presented on (date and time) _____

By: (name and title) _____