



## Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.**

**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

The Southern Illinois University School of Dental Medicine is required by applicable federal and state law to maintain the privacy of your health information, to notify you of our legal duties and privacy practices, as well as your rights concerning the use and disclosure of your personal health information. Our duties and your rights are set forth more fully in 45 CFR Part 164 of the law. The School must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect immediately and will remain in effect until replaced by the School.

The School reserves the right to change its privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. The School reserves the right to make changes in its privacy practices as necessary and to make the changes effective for all personal health information maintained by the School. In the future, when the School makes a significant change in our privacy practices, we will post a copy of the current Notice on our website at <https://www.siu.edu/dental/patient-clinics/becoming-a-patient/policies.shtml> . The new Notice will be available to you upon request. You may request a copy of this Notice at any time.

For more information about these privacy practices, for additional copies of this Notice, or if you have questions or concerns, please contact the Privacy Officer, who is the designated contact person at (618) 618-474-7080.

### 1. USES AND DISCLOSURES WE MAY MAKE WITHOUT WRITTEN AUTHORIZATION: TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The School is allowed by law to use and disclose health information about you for treatment, payment, and healthcare operations.

- **Treatment:** The School may use or disclose your health information to its students, faculty, staff, residents, fellows, other health care personnel who manage your health care, and any medical and/or dental laboratories that are involved in your dental care and treatment. For example, a dentist or physician working in consultation with your treatment may need to review a copy of your dental record in order to provide appropriate treatment and follow up care.

- **Payment:** The School may use and disclose your health information to insurance companies, collection agencies and other third parties to obtain payment for services provided to you. We may send information regarding your dental procedures and treatment to your insurance company to arrange payment for the services that have been provided to you. If you have paid for your services out-of-pocket, in full, you may request that the School not disclose your protected health information related to those services to a health plan and the School must accommodate your request except where the School is required by law to make a disclosure. (45 CFR §164.520(b)(1)(iv)(A).

- **Healthcare Operations:** The School may use and disclose your health information in connection with its healthcare operations. Healthcare operations includes those activities that support the day to day functions of the dental clinic, including but not limited to, quality assessment and improvement activities, evaluating students and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. Information may be shared between departments and will be provided only on a “need to know” basis. The School is a teaching institution and may disclose your health information to dentists, nurses, technicians, students in health related fields, other health care and clinic personnel for teaching purposes. The School is prohibited from disclosing genetic information for insurance purposes. 45 CFR164.520 (b)(1)(iii)(C).

## 2. USES AND DISCLOSURES FOR OTHER REASONS WITHOUT YOUR AUTHORIZATION:

There are other limited purposes where the law allows the School under 45 CFR § 164.512 or other applicable laws and regulations to use or disclose your health information without your authorization. Such uses and disclosures are identified as follows:

- As mandated by state or federal law, such as to report child abuse or neglect. The School may disclose your health information to appropriate authorities if it reasonably believes that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes
- Public health purposes for reporting, preventing or controlling disease, public surveillance, health investigations, health interventions, and notices to the Federal Drug Administration (FDA) regarding drugs or medical devices.
- Uses for health oversight such as the regulation of professional licenses, audits by Center for Medicare and Medicaid Services (CMS) or investigations related to health care laws
- Disclosure in judicial or administrative proceedings, such as responses to subpoenas, court orders, administrative agencies, or similar process of law enforcement activities
- Disclosure to medical examiners, coroners, funeral directors or organ procurement organizations as necessary to allow them to carry out their duties and responsibilities.
- For specialized government functions. To prevent a serious threat to health safety and National Security: For lawful national intelligence activities, military and veteran purposes or for correctional institutions.
- For research purposes if information is de-identified or contains limited data sets.
- Disclosure to business associates who perform health care operations for the School.

**Business Associates:** Certain aspects and components of our services are performed through contracts with outside persons or organizations. At times it may be necessary for us to provide certain of your personal health information to one or more of these outside persons or organizations who assist us with your health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information consistent with all applicable privacy laws.

- Workers' compensation laws for use in workers compensation proceedings.
- In response to certain requests from law enforcement for the purpose of locating a fugitive, victim or witness, or to report death or certain crimes.

3. **DISCLOSURES WE MAY MAKE UNLESS YOU OBJECT:** Unless you otherwise instruct us in writing, we may disclose your information to family and friends involved in your care if the member of your family, relative, friend or other person is involved in your healthcare or the payment for your healthcare.

4. **USES and DISCLOSURES WHEN YOUR WRITTEN AUTHORIZATION IS REQUIRED:** Any uses or disclosures other than those permitted by law will be made only with your written authorization. Other uses or disclosures that require your written authorization include the use or disclosure of psychotherapy notes, marketing purposes, and disclosures that involve the sale of protected information to any outside marketing firm or agency. You may revoke your authorization in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect but only future uses and disclosures. Unless you give the School a written authorization, it cannot use or disclose your health information for any reason except those described in this Notice as provided by 45 CFR §164.508(b)(5).

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## **PATIENT RIGHTS**

**Breach Notification:** The School is required by law to notify you of any breach of your unsecured protected health information.

**Access:** You have the right to look at or obtain copies of your health information, with limited exceptions as provided by law. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must complete and sign an "Authorization to Release Dental and Medical Information Form." We will charge you a reasonable cost-based fee for expenses such as copies, supplies and labor costs associated staff making the copies. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, and agree in advance, we will prepare a summary or an explanation of your health information for a fee.

**Disclosure Accounting:** You have the right to receive a list of instances in which the School or its business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, made in the last six years or less, prior to the date on which the accounting is requested. If you request this accounting more than once in a 12-month period, the School may charge you a reasonable, cost-based fee for responding to these additional requests if

you are informed of the fee in advance and provided an opportunity to withdraw or modify the request to avoid or reduce the fee.

**Restriction:** You have the right to request that the School place additional restrictions on its use or disclosure of your health information. The School is not required to agree to these additional restrictions, but if it does, it will abide by our agreement, except in an emergency.

**Alternative Communications:** We may contact you to provide appointment reminders or test results. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders not to be left on your voice mail or sent to a particular address, we will accommodate reasonable requests. You must request such confidential communication in writing.

**Amendment:** If you believe that there is an error in your personal health information, you have the right to request that the School amend your health information. Your request must be in writing, and it must explain why the information should be amended. The School may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on the School's Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

### **QUESTIONS AND COMPLAINTS**

If you want more information about the School's privacy practices or have questions or concerns, please notify the Privacy Officer, who is the designated contact person.

If you are concerned that the School may have violated your privacy rights, or you disagree with a decision made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have the School communicate with you by alternative means or at alternative locations, you may file a complaint with SIU SDM, the Secretary of Human Services or the Office of Civil Rights as outlined in **Section 2.200: Complaints; Complaint Procedures; No Retaliation** of the SIU SDM HIPAA Manual.

The School will support your right to the privacy of your health information and will not retaliate in any way if you choose to file a complaint with the School or with the U.S. Department of Health and Human Services.

Contact Information. If you have any questions about this Notice or if you want to object, file a complaint regarding any use or disclosure, or exercise any right as explained in this Notice, please contact the Privacy Officer.

**Privacy Officer: Assistant Dean for Clinical Affairs, Telephone Number: 618-474-7080**

**Address: 2800 College Avenue Bldg 263 Alton, IL 62002**

**Effective Date: This Notice is effective September 1, 2013; Revised March 22, 2016**



**INFORMED CONSENT FOR  
ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_, have received a copy of the Southern Illinois University School of Dental Medicine's (SDM) Notice of Privacy Practices.

**Additional Releases if applicable:**

I hereby request and authorize the SDM to disclose and provide Personal Health Information to the individual or agency listed below:

1. \_\_\_\_\_  
Name of individual or agency to receive Personal Health Information Telephone #

2. \_\_\_\_\_  
Name of individual or agency to receive Personal Health Information Telephone #

3. \_\_\_\_\_  
Name of individual or agency to receive Personal Health Information Telephone #

4. \_\_\_\_\_  
Name of individual or agency to receive Personal Health Information Telephone #



\_\_\_\_\_  
Patient's or Legal Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient