Important items to bring to your appointment:

1. ID card
2. SDF application (if not already turned in)
3. Insurance card (if applicable)
4. Informed consent (i.e. who authorizes treatment, proof of authorization)
5. Face sheet/demographic form
6. Medical/Dental history; unless turned in with SDF application
7. List of medications

Offsite Health History

Patient's name: _____ Date: _____

Patient History

General Questions

Chief Complaint: _____

How long have you had this condition for? _____

How would you rate your health? Excellent Good Fair Poor

Are you under the care of a physician? Yes No

If Yes, Dr's name: _____

Phone #: _____

Reason: _____

Have you ever been admitted to a hospital? Yes No

If Yes, please provide brief explanation of when and why _____

_____

_____

Have you ever had previous operations? Yes No

If Yes, please provide brief explanation of when and why _____

_____

_____

Blood Pressure

Enter last BP and Date _____

Is the patient's BP generally Abnormally High Abnormally Low Neither

Has he/she ever had… (circle all that apply)

Heart Problems:

Heart Attack/MI, Angina/chest pain, Hypertension, Prosthetic Heart Valve, Congestive Heart Failure, PaceMaker/Defibrillator, Infective Endocarditis, Heart Palpitations, Irregular Heartbeat, Rheumatic fever, Rheumatic heart disease

Please give any information that you feel is important to know about the circled issues

_____

Breathing Problems:

Asthma, Tuberculosis, Sleep Apnea, Bronchitis/emphysema/COPD, Cough, Shortness of breath, Pneumonia

Please give any information that you feel is important to know about the circled issues

_____

Blood Problems:

Anemia, Sickle cell disease, HIV/AIDS, Bleeding disorders (Hemophilia), Warfarin/Coumadin treatment, Bruising easily

Please give any information that you feel is important to know about the circled issues

_____

Head, Eyes, Ears, Nose or Throat Problems:

Frequent Headaches, Jaw joint/TMJ popping, catching, or pain, Glaucoma, Sinus/Nasal

Please give any information that you feel is important to know about the circled issues

_____

Digestive Problems:

Hepatitis/Jaundice, Liver disease, GERD/reflux/ulcers

Please give any information that you feel is important to know about the circled issues

_____

Endocrine Problems:

Diabetes or Thyroid disorder

Please give any information that you feel is important to know about the circled issues

_____

Nervous System Problems:

Stroke/TIA/Mini Stroke, Epilepsy/Seizure Disorder, Neuropathy/Nerve Pain

Please give any information that you feel is important to know about the circled issues

_____

Psychiatric Problems:

Depression, Panic/Anxiety Disorder, Other Psychiatric/Emotional Disorder

Please give any information that you feel is important to know about the circled issues

_____

Other Problems:

Renal/Kidney/Prostate disease, Organ Transplant, Cancer/Tumors,

Radiotherapy/Chemotherapy, Arthritis, Joint Replacement,

Other: _____

For Women Only

Are you nursing?	Yes	No
Are you or could you be pregnant	Yes	No

Family History of… (circle all that apply)

Cancer

Arthritis

Heart Disease

Hypertension

Anesthesia Complications

Has he/she ever used... (circle all that apply)

Tobacco

Alcohol

Recreational Drugs

Is he/she ALLERGIC to… (circle all that apply)

Aspirin

Iodine

Pain Medicine

Penicillin/Amoxicillin

Other Antibiotics
Local Anesthetics
Other Medicines
Latex Gloves or Powder
Environmental/Seasonal Allergies
Other Allergies Please list: _____
_____

Medications (circle all that apply) ***Provide copy of list if possible

Anticoagulants (blood thinners)
Aspirin
Coumadin
Plavix
Bisphosphonates (Boniva, Reclast, Fosamax, Aredia, Zometa)
Steroids
Birth Control
Other Medicines/Supplements **Please list OR ATTACH LIST W/APPLICATION**

_____
_____
_____
_____
_____

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____

UF UNIVERSITY of FLORIDA
Dental Clinic
The University Partnership Center
St. Petersburg College Seminole Campus

9200 113th Street North
Seminole, Fl. 33772
Telephone: (727) 394-6064
Fax: (727) 394-6098

Patient's Name: _____ Date: _____

Date of Birth: _____

Name and complete address if patient's dentist: _____

_____

Developmental Disability: _____

Dental Screening:

____ *YES*, I want to receive a dental screening

Oral Hygiene Training:

____ *YES*, I want to receive **routine** hands-on oral hygiene training and monitoring

Fluoride Varnish Treatment:

____ *YES*, I want to receive routine fluoride varnish treatments

Are you allergic or sensitive to any form of dentifrice (toothpaste) and/or fluoride? YES NO

_____ _____

Patient/Parent/Guardian Signature **Date**

A dental screening (charting) may be performed. The screening has limitations and is not a substitute for a comprehensive dental examination. The purpose of dental charting is to collect data. The Special Needs Dentistry: Community Outreach Program strongly advises each participant to receive a complete examination by a dentist who can render a professional diagnosis of his/her oral health needs. The diagnosis of caries, soft tissue disease, oral cancer, tempro-mandibular joint disease (TMJ), and dentofacial malocclusions can only be completed by a dentist in the context of delivering a comprehensive dental examination. The preventative services are in place to help support and enhance the participant's current dental care and to offer assistance to those who are lacking in such supports. Open communication with any existing dentist is encouraged; and for those who are without a dentist, a referral to our existing program can be made by the dental hygienist.

Dental Hygienist: Whitney Haley **Signature:** _____

License Number: DH21972 **Place of Employment:** University of Florida College of Dentistry

Location where dental charting will be performed: Adult Day Training program or Group home/residence with support staff/guardian present.

Special Day Foundation

Creating Special Days For Special People

Notice of Participant Responsibility Policy:

Special Day Foundation works with the University of Florida through its **St. Petersburg Dental Clinic** to improve access to dental funding and services for individuals with developmental disabilities. The Clinic provides a multitude of specialized services to a considerable number of local citizens who desperately need this care. Special Day Foundation does its best to raise funds to pay for care that individuals with special needs cannot afford.

To offer this program to as many patients as possible, a tremendous amount of coordination is needed to make sure that the right staff and equipment are secured. When a participant fails to present to an appointment or cancels an appointment on short notice, it prohibits the Dental Clinic from being able to provide care for another individual and, in most cases, costs the Clinic for the time of professional staffing while providing no care. **It is imperative that you attend each appointment once it has been scheduled.** The **NO CANCELLATION POLICY** of this program is necessary to preserve funds and Dental Center access, this policy also includes any scheduled offsite dental visits.

Please initial all 4 statements and sign below.

____ I understand that Special Day Foundation follows and supports **St. Petersburg Dental Clinic's** cancelled/failed appointment policy.

____ I understand that if I fail or cancel an oral sedation, IV sedation, or an operating room appointment, all services will cease from the cancelled/failed appointment date forward, unless significant reason has been reviewed and approved by the Director of the Dental Clinic.

____ I understand that once all insurance options have been exhausted, funds for dental care may be provided by Special Day Foundation to help with expenses associated with dental care. Costs approved by Special Day Foundation to assist in payment will be shared with you prior to the start of any treatment. There is no guarantee that Special Day Foundation will cover all remaining costs.

____ I understand that Special Day Foundation will not commit to funding dental care that will be rendered during operating room appointments unless the operating room fee will be covered by insurance.

_____ _____

Participant Name Guardian Name

_____ _____

Participant/Guardian Signature Date

Patient Supplemental Form

Patient's Name: _____
Parent/Guardian: _____

Developmental Disability: _____

Describe patient's communication process: _____

Does he/she have difficulty with hearing or visions? Yes No
If yes, please explain _____

Are there any specific physical/behavioral challenges that we should be aware of? Yes No
If yes, please explain _____

Has he/she visited the dentist before? Yes No
If yes, please describe tolerance for dental experience _____
_____

Is he/she able to brush independently without parent/caregiver assistance? Yes No
Does he/she regurgitate or pocket food between cheeks or lips? Yes No
Does he/she have gastroesophageal reflux or episodes of vomiting? Yes No
Does he/she experience dry mouth? Yes No

Contact/Offsite Visitation Location Info

Does he/she live in a group home? Yes No
If Yes please provide the following: **Name of Group Home** _____
Address _____

Phone Number _____

Who to contact to schedule visits _____

Phone Number _____

Does he/she attend an Adult Day Training Program? Yes No
If yes please provide the following: **Name of program** _____
Address _____

Phone Number _____ **Supervisor** _____

Week days he/she attends program _____

****The Special Day Foundation** provides a biannual newsletter discussing updates about the program as well as upcoming events. Educational topics/information for parents and caretakers will also be provided in each newsletter. Provide your email address below if you would like to receive the **Special Day Foundation newsletter**.

Email _____ **Patient's Email** _____

UFCD PATIENT REGISTRATION

Patient's Full Name: _____ **Date:** _____

Home Address: _____ Zip Code: _____

Home Phone: _____Date of Birth: _____ Sex: _____

Parent Guardian's Full Name: _____

Emergency Contact:

Name: _____ Phone_____

Relationship: _____

If the Parent/Guardian's address is different than above, complete the following:

Address: _____ Phone: _____

Primary Insurance Company Information:

Name of Insurance Company: _____ Phone: _____

Address: _____

Insurance/Group Number: _____

Medicaid No: _____ **Medicare No:** _____

If the policy is not the patient, then complete the following:

Name: _____

Address: _____

Date of Birth: _____ Patient's Relationship to Insured Party: _____

The optional demographic and financial information is being asked to better understand the individuals served by the College of Dentistry. This information is used to request additional funds from the government and other sources to help keep the cost of dental care affordable to our patients.

Gross Annual Household Income: _____ Number in Household: _____

Ethnic Origin: _____

I give the University of Florida - College of Dentistry, permission to bill all applicable insurance(s) for preventative service rendered through the Special Needs Dentistry: Community Outreach Program. I understand that if the treatment is not covered by insurance, Special Day Foundation will fund the dental screening, oral hygiene training, and/or fluoride vanish treatment provided at the organization's facility.

Patient/Parent/Guardian Signature: _____ **Date:** _____

UF | Compliance & Ethics
Privacy Office
UNIVERSITY *of* FLORIDA

AUTHORIZATION to Use or Disclose Protected Health Information for Public Activities

The Protected Health Information (PHI) described below may be used or disclosed for: *Check all that apply:*

☑ Marketing Activities ☑ Fundraising Activities ☑ Public Relations Activities at UF ☑ Educational Purposes ☑ Publication (Article, Journal, Book) ☐ Sale of PHI

☑ Other Public Activity (*specify*): Newsletter

Patient Name		*Verification of Identity (Driver's License, ID Card, Passport, etc.)*	
Patient's Address			*Date of Birth*

Complete the following only if the person authorizing the use or disclosure is not the patient:

Name	Relationship to Patient	*Verification of Identity*	*Verification of Authority*
Representative's Address	*Phone #*	*Email Address*	

See the UF Policy for Verification of Identity and Authority and Personal Representatives in the Operational Guidelines.

By signing this form, I authorize the following: PHI about me / the patient, described below and held by **The *University of Florida***, may be used or disclosed ***from*** records about my care and treatment provided by:

(College, Department, Clinic, Physician, or Other Person)
Specify:

My / the patient's PHI may be **used by** and/or **disclosed to**:

☑	The General Public via print, radio, television, Internet, or other methods
☐	A specific entity or person only (*specify*):

Address, if known:	*Contact/Responsible Party:*	*Phone/Email/Other Contact:*

The following PHI relating to the patient named above may be used or disclosed: *Check all that apply:*

☑ Name ☑ Address ☑Photograph(s) – Full-face or Identifiable image ☑ Photograph(s)
☑ Diagnosis ☑ Prognosis ☑ Treatment ☑ Treating Department /Clinic ☑ Testimonials ☑ Physician/caregiver name and specialty ☑ Other: Educational purposes outside of UF

I further authorize the disclosure of the following information about me that may be included in the PHI listed above.
(Check all that are approved.) ☐ Mental Health ☐ Substance Abuse ☐ STD/HIV/AIDS ☐ Genetic Data

- I understand that, by federal law, UF may not use or disclose protected health information (PHI) without authorization except as provided in UF's Notice of Privacy Practices. By signing this Authorization, I am giving permission for the use or disclosure of the PHI described above for the purpose(s) described. I hereby release the University of Florida and its employees from any and all liability that may arise from the release of information as I have directed. I have the right to receive a copy of this form and the Health Information released.
- I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. The revocation will not apply to any information already released as a result of this authorization.
- I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.
- I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal health information privacy law and could be re-disclosed by the person or agency that receives it.

I understand that the University of Florida ☐ Will ☑ Will not receive remuneration for this use or disclosure

This authorization expires automatically: ☐ In 1 Year ☐ In 2 years ☑when I revoke it in writing, after which no further uses or disclosures of the PHI described above may be made.

Signature of Patient or Legal Representative: Date

Complete all parts of the form, print out and sign and date. Patient or representative should keep a copy. Give, fax, email, or mail the original form to the person or organization releasing the information. Information Privacy Policy & Procedure Manual Health Information Privacy Forms. © Copyright 2003-2020. University of Florida. All rights reserved. Version 09/28/2020

UF UNIVERSITY of FLORIDA
College of Dentistry

Combined Consent

NOTICE OF LIMITED LIABILITY

I, on behalf of myself, my child, and/or my ward, hereby acknowledge that the care, treatment and services ("care") received are provided by the employees and/or agents of University of Florida ("University"). The University employees and/or agents providing this care include, but are not limited to, dentists, dental assistants, residents, fellows, students, nurses, and technicians, who will at all times be under the exclusive supervision and control of the University. The liability for negligent acts and omission of these University employees and/or agents is limited by law to $200,000 per claim or judgment by any one person, and to $300,000 for all claims or judgments arising out of the same incident or occurrence, pursuant to Section 768.28(5), Florida Statutes.

Authorization for Treatment

I hereby certify that I can read, write and understand the English language and hereby consent to and authorize the University of Florida College of Dentistry (UFCD) faculty/staff/students to perform any tests or treatments that, in their judgment, are considered necessary and advisable for the detection, diagnosis and treatment of oral diseases. I understand that UFCD's policies regarding infectious diseases are available on request. I authorize the dentist to administer local anesthetics and other medically-indicated drugs or pharmaceuticals and to use dental materials deemed necessary for operative and technical procedures necessary for diagnosis and/or recommended treatment.

Consent to be photographed for Diagnostic and/or Educational Purposes

I consent to the UFCD faculty/staff/students taking photographs and/or video in the course of and related to my treatment, and to their use of the photographs or videos and my medical data for diagnostic and/or educational purposes. I understand that in any use I will not be identified by name, and the photographs or videos may be modified or retouched at my dentist's discretion. I also understand separate authorization is required to print any photo (in any form) where I can be recognized or my name will be used.

Payments of Benefits

I authorize payment of benefits, determined by the insurance company, directly to the surgeon or dentist: Yes (If you check "no," payments will be paid directly to the patient.) I also understand that I may be responsible for any amount not paid by insurance. (**Insurance is not accepted in DMD undergraduate clinic.)**

Release of Information

I authorize UFCD and my providers to release my health information and any other information for treatment purposes and/or to obtain payment for charges incurred by me or on my behalf to: my providers or any affiliated provider; my referring or treating providers; any third party engaged in the collection or dissemination of my medication information; the guarantor on my accounts; any third party payors (defined as including, but not limited to, Medicare, Medicaid, Tri-care or governmental programs; dental, health, accident, automobile or other insurance; workers' compensation payors, agents or administrators; HMOs; self-insured employers; and any sponsors who may contribute payment for dental services) or their agents; regional or national health information networks; and other providers of dental services and products related to or connected with this admission or course of Care.

I authorize UFCD to disclose my patient information to: business associates, public health and oversight agencies, regulatory entities, other health care providers or organizations who have provided

me with Care to facilitate health care operations of any of these parties; residents, interns, students, and others in furtherance of educational purposes; disaster relief agencies as necessary to assist in their endeavors; law enforcement to correctly identify me or to report a crime; affiliated charitable foundations in connection with fundraising programs; and UF Health to send health promoting or informational materials to me. If my admission or treatment is due to a motor vehicle accident, I authorize UFCD or my providers to obtain a copy of my "crash report" required by Florida Statutes, in order to facilitate third party payment.

I understand that my patient information is protected by the right to privacy guaranteed by Article 1, Section 23 of the Florida Constitution. I do not authorize the release of my patient information, including the release of information with my name or identifying information redacted, if requested by other patients or their representatives.

Risk Management and Dispute Resolution

I agree that my patient information (including, but not limited to, my medical records, billing information, and information I disclose to a health care provider in the course of my care) may at any time be used by and disclosed to employees, officers, agents, and legal representatives of the University for purposes of risk management, and formal and informal dispute resolution processes (including, but not limited to, litigation and mediation) involving one or both of these entities.

Agreement to Mediate

In accepting care at a University facility, I agree that before I file any lawsuit against the University or any of its facilities, employees or agents, and/or the University of Florida Board of Trustees, arising out of the care provided to me by dental healthcare providers, I will first attempt to resolve my claim through confidential mediation. Mediation is a process through which a neutral third party person who has been certified to be a mediator tries to help settle claims. The University will pay the cost of the mediator. I further agree that any mediation must take place in the State of Florida and in the county where my treatment was rendered, unless all parties agree otherwise. This agreement is binding on me and any entity or individual making a claim on my behalf. This agreement does not waive my right to file a lawsuit if the mediation process fails to resolve my claim. I understand that lawsuits must be filed within a certain period and that the time for me to file a lawsuit is not extended as a result of my participation in mediation.

Guarantor Agreement

I agree to pay all charges connected with this treatment. I understand that insurance coverage or sponsorship does not release me from the obligation to make payments. I consent to the University or any third party contacting me by telephone, including my cellular phone, for purposes of collecting any amounts owed by me.

Acknowledgement of Receipt of Privacy Practices

I have been provided a copy of the Joint Notice of Privacy Practices for the University of Florida.
I understand that I may ask questions about this Notice at any time.

Acknowledgement of Patient Rights and Responsibilities

I have been provided a copy of the Patient Rights and Responsibilities for the University of Florida.
I understand that I may ask questions about this Notice at any time.

Scheduling Communications

I understand that I may be contacted via email, text, and/or voice mail by the COD in order to confirm or remind me of upcoming appointments, and will keep my contact information current. .

I further understand that I may opt out of text or email scheduling services at any time. To opt out of text messages, reply "STOP" at any time. To opt out of emails, simply click the "Unsubscribe" link in any message.

Credit Balances

Credit account balances under $10.00 will only be refunded at the request of the patient.

_____ _____ _____

Date Guardian:

and include an explanation of your reason(s) for the amendment. The request must be submitted on the proper form to the Health Information Management or Clinic Manager where you received treatment.

- **Right to an Accounting of Disclosures**
  You have the right to request an Accounting of Disclosures. This Accounting of Disclosures report does not include disclosures made for your treatment, payment, or health care operations. It also does not include disclosures made to or requested by you, or that you authorized.

  You must submit your request for a report in writing to the Health Information Management or the Clinic Manager where you received care. Your request must state a time period, which is limited to the previous six years from the date of the request. The first request for an accounting of disclosures will be provided free of charge. We may charge you for additional report requests made within a 12 month period.
- **Right to Request Restrictions**
  You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. If we agree with your request, we will comply unless the information is needed to provide emergency treatment, is required by law, or otherwise required to be disclosed as listed in this notice.

  You must make your request for restrictions in writing to either the UF Health Shands Privacy Office or the UF Privacy Office. Your request must include what information you want to limit and how you want the limits to apply.

  You have the right to restrict disclosures of health information made to a health plan when the items or services were paid in full prior to being rendered. Certain limitations apply.
- **Right to Choose How We Communicate With You**
  You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example: you can ask that we only contact you at work or by mail. You must make your request for alternate communications in writing to the Admissions supervisor at UF Health Shands, or to the UF Clinic Managers or supervisors. We will not ask you the reason for your request and will accommodate reasonable requests.
- **Right to a Paper Copy of This Notice**
  You have the right to receive a copy of this notice from UF Health Shands or any UF clinic. You may obtain an electronic copy of this notice from our websites at: https://ufhealth.org/patient-care or www.privacy.health.ufl.edu.
- **Right to Breach Notification**
  You have the right to and will receive notification in the event of a breach of your unsecured protected health information, unless such notification is exempted by law.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us. You will not be penalized or denied services for filing a complaint. To file a privacy complaint with UF Health Shands, please contact the Privacy Office, at, P.O. Box 103175, Gainesville, FL 32610-3175, or call 1-866- 682-2372. To file a privacy complaint with the UFHSC or UF Clinics, please contact the UF Privacy Office at P.O. Box 113210, Gainesville, FL 32611 or call 1-866-876-4472. All complaints must be submitted in writing on the appropriate form that is available on our website: www.privacy.health.ufl.edu. To file a complaint with the Secretary of the Department of Health and Human Services, visit the Office for Civil Rights website at www.hhs.gov/ocr.

*The University of Florida clinics and physicians' offices; the Florida Clinical Practice Association; the University of Florida Jacksonville Physicians, Inc., the University of Florida Jacksonville Healthcare, Inc.; the University of Florida Colleges of Medicine, Nursing, Health Professions, Dentistry and Pharmacy; the University Proton Therapy Institute; and other affiliated health care providers, including all employees, volunteers, staff and other University of Florida health services staff.

UFHealth
UNIVERSITY OF FLORIDA HEALTH

UF | UNIVERSITY of FLORIDA

JOINT NOTICE OF PRIVACY PRACTICES AND NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT

Effective Date: September 23, 2013

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.

If you have any questions about this Notice, please contact either the Privacy Office for UF Health Shands or the Privacy Office for the University of Florida at the contact information listed below:

UF Health Shands Privacy Office 1-866-682-2372
University of Florida Privacy Office 1-866-876-4472

OUR LEGAL DUTY TO PROTECT HEALTH INFORMATION ABOUT YOU

We understand your health information is personal and we are committed to protecting it. We create a record of the care and services you receive at UF Health Shands or the University of Florida Health Science Center (UFHSC) to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by UF Health Shands and/or the UFHSC, whether made by hospital personnel, University of Florida faculty, staff, students, or your personal doctor. This Notice describes how we may use and disclose your health information, and provides examples where necessary. This Notice also describes your rights regarding your health information.

We are required by law to maintain the privacy of health information, to provide individuals with notice of our legal duties and privacy practices with respect to health information, and to abide by the terms of the notice currently in effect.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and this notice at any time. We reserve the right to make the revised notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at all our facilities.

NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT

UF Health Shands, which for the purposes of this notice includes Shands Teaching Hospital and Clinics, Inc. and Shands Jacksonville Medical Center, Inc., and the UFHSC, together with the UFHSC clinics* and other affiliated health care providers have agreed as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations. This arrangement enables us to better address your health care needs in the integrated setting found within UF Health Shands and the University of Florida health care providers.

The organizations participating in the Joint Notice are participating only for the purposes of providing this Joint Notice and sharing medical information as permitted by applicable law. These organizations are not in any way providing health care services mutually or on each other's behalf. UF Health Shands and the University of Florida are separate health care providers and each is individually responsible for its own activities, including compliance with privacy laws, and all heath care services it provides.

(continued)

CONSISTENT WITH STATE AND FEDERAL LAW, WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN PERMISSION IN THE FOLLOWING CIRCUMSTANCES:
We may use and disclose your health information to **provide medical treatment to you and to coordinate or manage your health care and related services.** This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example: we may use and disclose your health information when you need lab work or an x-ray. Also, we may use and disclose your health information when referring you to another health care provider or to recommend treatment alternatives to you.

We may use and disclose your health information to **bill and receive payment for services rendered.** For example: A bill may be sent to you or your insurance company. The items on, or accompanying, the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used so that your health plan will pay the medical bill. We may also tell your health plan about a treatment you are expected to receive in order to obtain prior approval or to determine if your health plan will pay for that treatment.

We may use and disclose your health information for **health care operations.** We will use your health information for regular operations of the hospital and clinics to provide patients with quality care. For example: Members of the medical staff, the risk management team or the quality improvement team, including Patient Safety Organizations (PSOs), may use information in your health record to assess the care you receive and the outcomes of your treatment. We may also disclose information to doctors, nurses, technicians, medical students and other UFHSC personnel for review and teaching purposes.

We may also use and disclose your health information:

- When necessary to **prevent a serious threat to your health and safety** or the health and safety of the public or another person.
- To **organizations that facilitate donation and transplantation** of tissues and/or organs.
- To **authorized officials** when **required by federal, state, or local law.**
- In response to a **subpoena, court, or other administrative order.**
- As required by law, for **public health activities.** For example: preventing or controlling disease, reporting births and deaths, and reporting abuse and neglect.
- For authorized **Worker's Compensation activities.**
- To **health oversight agencies.** For example: agencies that enforce compliance with licensure or accreditation requirements.
- To **coroners, medical examiners, or funeral directors** to carry out their duties.
- As required by **military command authorities,** if you are a member of the armed forces.
- To our **business associates** to carry out treatment, payment, or health care operations on our behalf. For example: we may disclose health information about you to a company who bills insurance companies for our services.
- For **research or to collect information in databases** to be used later for research. All research projects are reviewed and approved by an independent review board to protect the privacy of your health information.
- To a **correctional institution having lawful custody of you** as necessary for your health and the safety of others.

We may also use and disclose your information for **fundraising activities** to raise money for UF Health Shands or the UFHSC and their operations. If you do not want to be contacted for fundraising efforts, you must notify either the UF Health Shands Privacy Office or the University of Florida Privacy Office.

SPECIAL CIRCUMSTANCES
Alcohol, Drug Abuse, Psychotherapy Notes, and Psychiatric Treatment Information may have special privacy protections. We will not disclose any health information identifying an individual as a patient or provide information relating to the patient's substance abuse or psychiatric treatment unless:

1. You or your personal representative consents in writing;
2. A court order requires disclosure;
3. Medical personnel need information to treat you in a medical emergency;
4. Qualified personnel use the information for research or operations activities;
5. It is necessary to report a crime or a threat to commit a crime; or
6. To report abuse or neglect as required by law.

YOU MAY REFUSE TO PERMIT CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION
Unless you object, we may use or disclose your health information in the following circumstances:

- **Hospital Directories.** We may share your name, room number, and condition in our patient listing with clergy and with people who ask for you by name. We also may share your religious affiliation with clergy.
- **Individuals Involved in Your Care or Payment for Your Care.** We may use or disclose information to a family member, legal representative, or other persons involved with or responsible for your care or the payment of your care.
- **Emergency Circumstances and Disaster Relief.** We may disclose information about you to an agency assisting in a disaster relief effort so that your family can be notified of your location and general condition. Even if you object, we may still share the health information about you, if necessary for emergency circumstances.

USES AND DISCLOSURES OF HEALTH INFORMATION THAT REQUIRE YOUR WRITTEN PERMISSION
Other uses and disclosures of health information not covered by this notice or applicable law will be made only with your written permission. If you provide permission to use or disclose health information, you may revoke that permission at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your revocation. We are unable to take back any disclosures already made with your permission.
We will not use or disclose your protected health information for marketing purposes, nor will we sell your protected health information without your written permission.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION
You have the following rights regarding health information we maintain about you:

- **Right to See and Obtain Copies of your Health Information**
  You have the right to see and obtain copies of health information used to make decisions about your care. Usually, this includes medical and billing records, and excludes psychotherapy notes.

  To view and copy your health information, you must submit your written request on the appropriate form to Health Information Management or the Clinic Manager. We may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to see and obtain copies of your health information in certain very limited circumstances. You have the right to appeal the denial.

- **Right to Amend**
  If you think that your health and billing information is incorrect or incomplete, you may ask us to correct it. We may deny your request if:

  1) The information was not created by us;
  2) The information is not part of the records used to make decisions about your care;
  3) We believe the information is correct and complete; or
  4) You do not have the right to review parts of the medical record under certain circumstances.

  We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial.

  If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, as needed, including persons you name who have received information about you and who need the amendment. Your request must be in writing

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