OFFICE OF ORAL HEALTH

CONFIDENTIAL CONSENT FOR *FREE* DENTAL SEALANTS

YES **NO** **DO YOU WANT YOUR CHILD TO RECEIVE DENTAL SEALANTS?** ***(Circle answer.)***
(If YES, please fill out entire form. If NO, provide child's name, DOB and your initials next to "NO")

Name of Child (*print*): _____ Grade: _____

School: _____ Teacher: _____ Room: _____

Child's Date of Birth: _____ / _____ / _____
(*Month*) (*Day*) (*Year*)

Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Ethnicity (*please circle*): 1) White 2) Black 3) Hispanic 4) Asian
5) American Indian 6) Pacific Islander 7) Other

Gender: (*please circle*): Male Female

Does your child see a dentist regularly? (*Please circle*): **Yes** **No**

When was the last visit to the dentist? Date _____

Does you child have dental insurance? (*Please circle):* Private Dental Insurance Medicaid None

HEALTH HISTORY

1. Does your child have any health or heart problems? **Yes** **No**
   If yes, please explain: _____
2. Is your child taking medication on a regular basis? **Yes** **No**
   If yes, please list: _____
3. Is your child allergic to any medications or products? **Yes** **No**
   If yes, please list: _____
4. Does your child have a disability or special care needs? **Yes** **No**

Please do not let fear of the U.S. Citizenship and Immigration Services (USCIS) keep you from enrolling your child in this program.

I understand by signing below, I am giving consent to the Office of Oral Health to check my child's teeth and apply dental sealants.

Should you have questions about the dental sealant program please call the Office of Oral Health at (505) 827-0837.

Parent /Guardian Name (*please print*): _____

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

Phone *(home):* _____ ***(work):*** _____ ***(cell):*** _____

(Español a el otro lado)

Public Health Division • 1190 St. Francis Dr., Suite N-1055 • P.O. Box 26110
Santa Fe, New Mexico • 87502-6110 • (505) 827-0837 • FAX: (505) 827-0021

OFICINA DE SALUD ORAL

CONSENTIMIENTO CONFIDENCIAL PARA RECIBIR SELLANTES DENTALES

SI **NO** **QUEIERE USTED QUE SU NIÑO RECIBA SELLANTES DENTALES? (*Por favor marque*)**
(Si desea este servicio, favor de completar el formulario. Si NO, solo nombre del niño, cumpleaños, y las iniciales suyas)

Nombre del niño (*por favor en letra impresa*):_____Grado:_____

Escuela: _____ Maestro: _____ Salón: _____

Fecha de nacimiento del niño: _____/_____/_____
(Mes) (Día) (Año)

Dirección: _____Ciudad:_____

Estado: _____Código Postal: _____ Condado: _____

Etnia (*Por favor marque*): 1) Blanco 2) Afroamericano 3) Hispáno 4) Asiático
5) Indoamericano 6) Isleño del Pacífico 7) Otra

Género: (*Por favor marque*): Hombre Mujer

¿Su niño va a ver al dentista regularmente? **Sí** **No**

¿Cuándo fue la última vez que visitó a un dentista? Fecha _____

¿Su niño tiene seguro dental? (*Por favor marque*): Seguro Dental privado Medicaid Ninguno

HISTORIA DE SALUD

1. ¿Tiene su niño problemas de salud o del corazón? **Sí** **No**
   ¿Si? Explique por favor: _____
2. ¿Está tomando medicinas su niño regularmente? **Sí** **No**
   ¿Si? Explique por favor: _____
3. ¿Es alérgico su niño a alguna medicina o a algunos productos? **Sí** **No**
   ¿Si? Explique por favor: _____
4. ¿Tiene su niño alguna discapacidad o algunas necesidades especiales para su cuidado? **Sí** **No**

Por favor no deje que el miedo a los Servicios de Ciudadanía e Inmigración de los Estados Unidos (USCIS por sus siglas en inglés) le impida inscribir a su niño en este programa.

Yo entiendo que con mi firma abajo, permito que la Oficina de Salud Oral revise los dientes de mi niño y apliquen sellantes dentales.

Si tiene usted alguna pregunta sobre el programa de sellantes dentales, por favor llame a la Oficina de Salud Oral al (505) 827-0837.

Nombre de padre o guardián ***(letra impresa)*****:** _____

Firma de padre o guardián: _____ **Fecha:** _____

Teléfono ***(casa)*****:** _____ ***(trabajo)*****:** _____ ***(celular):*** _____

(English on other side)

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http://www.health.state.nm.us

NEW MEXICO DEPARTMENT OF HEALTH

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT FORM

The Health Insurance Portability Act of 1996 requires health agencies to provide a Notice of Privacy Practices to all persons receiving services. This form acknowledges that you have received the Department of Health Notice of Privacy Practices.

CLIENT		
	Client Name (First, Middle, Last)	Date of Birth (mm/dd/yyyy) / /
	Client Address (Street or P.O. Box, City, State, Zip Code)	Telephone Number ( )

I acknowledge that I was offered or provided a copy of the New Mexico Department of Health Notice of Privacy Practices.

SIGNATURES		
	Signature of Client or Personal Representative	Date (mm/dd/yyyy) / /
	If Signed by Personal Representative, Relationship to Client	

For Internal Use Only:

‰ Acknowledgment entered into CPO Database.

The following good faith efforts were made to obtain acknowledgment from the client or the client's personal representative. Please check all that apply.

‰ Offered the client or the client's personal representative a copy of the Notice of Privacy Practices and the client or the client's personal representative declined to sign the Acknowledgment Form.

‰ Provided answers to any questions from the client or the client's personal representative regarding the DOH Notice of Privacy Practices.

Aviso sobre la Privacidad de las Prácticas de Salud

FORMA DE RECONOCIMIENTO

La ley de 1996 llamada Health Insurance Portability Act requiere que las agencias de salud den a conocer el Aviso sobre la Privacidad de las Prácticas de Salud (o secreto profesional) a todas las personas que reciban servicios. Esta forma es para reconocer que usted ha recibido el Aviso sobre la Privacidad de los Procedimientos de Salud de lo Departamento de Salud.

PACIENTE		
	Nombre del Paciente (Apellido, Primer nombre, Segundo nombre)	Fecha de nacimiento (Mes/día/año) / /
	Dirección del Paciente (No. y Calle, Ciudad, Estado, Código Postal)	Número del Teléfono ( )

Yo reconozco que recibí una copia del Aviso sobre la Privacidad de las Prácticas de Salud del Departamento de Salud de Nuevo México expedida el 14 de abril de 2003.

FIRMAS		
	Firma del Paciente o su Representante Personal	Fecha (Mes/Día/año) / /
	Si es firmado por un Representante Personal, indique la relación con el Paciente	

Solamente Para Uso Interno

- Reconocimiento ingresado en el ICDS.

Los siguientes esfuerzos, en buena fe, fueran hechos como forma de obtener el reconocimiento del Paciente o de su Representante. Por favor, marque todos que son aplicables:

- Se ofreció al Paciente o su Representante Personal una copia del Aviso sobre la Privacidad de las Prácticas de Salud y el Paciente o su Representante se negaron a firmar la Forma de Reconocimiento.
- Se respondieran todas las preguntas del Paciente o de su representante Personal sobre el Aviso de la Privacidad de las Prácticas de Salud del DOH. (Department of Health).

SUSANA MARTINEZ, GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

LYNN GALLAGHER, CABINET SECRETARY

OFFICE OF ORAL HEALTH
DENTAL SEALANT INFORMATION FOR PARENTS

Dear Parent or Guardian:

The Department of Health/Office of Oral Health conducts a dental program at your child's school, a service to help prevent tooth decay. This service is called a dental sealant, which is a thin plastic that is placed on the chewing surface of permanent molar and premolar teeth where the toothbrush cannot reach. Dental sealants are safe to put on your child's teeth. **Regular dental visits are encouraged since they are important for good oral health.**

Children in elementary schools are eligible to receive **FREE** dental sealants (no charge to Medicaid or private insurance). A dental professional will assess your child's teeth to determine the need for dental sealant placement and may also recommend further examination by a dentist. The dental sealants will be placed by state licensed dental hygienists using recommended infection control procedures. If your child has participated in our program in the past, please continue to re-enroll him/her, as this is an ongoing program and sealants will be applied/reapplied as needed, because protection from decay is only possible while the sealant is in place. **Sealants do not take the place of regular dental care.**

A note will be sent home with your child explaining:

1. The number of sealants that were placed and the date the sealants were placed or:
2. Why dental sealants were not placed or;
3. If the dental hygienist suspects that the child needs additional services of a dentist. In select counties, a dental case manager will contact you and assist in obtaining dental services. The case manager will also follow-up with parents or guardians to ensure that a dental appointment has been made.

IMPORTANT

The Office of Oral Health is required by law to protect your privacy of the health information provided to the department. The law is called the Health Information Portability and Accountability Act, if you have questions please contact the Office of Oral Health.

The Office of Oral health needs your consent to check your child's teeth and to place dental sealants while the school participates in the program. Please fill out the consent form which has been provided and return it to your child's teacher tomorrow. The "Yes" box must be checked and the form signed. If you choose not to have your child participate, please indicate "No" on the form, provide your child's name and your initials then return it to your child's teacher.

THANK YOU

(Español a el otro lado

PUBLIC HEALTH DIVISION
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(505) 827-0837 • FAX: (505) 827-0021 • www.nmhealth.org

OFICINA DE SALUD ORAL
INFORMACION SOBRE SELLANTES DENTALS PARA LOS PADRES

Estimados Padres de Familia:

El Departamento de Salud/Oficina de Salud/Oral y la escuela de su niño(a) se complacen en ofrecer un servicio que ayuda a prevenir la caries dental. Este servicio se llama sellantes dentales. Los sellantes dentales son una capita de plastico que protegen contra la caries en las areas de las muelas donde el cepillo dental no alcanza. Los sellantes dentales estan a salvo para poner en las muelas. **Visitas regulares con su denista se recomiendan porque son importantes para mantener buena salud oral.**

Los estudiantes en las escuelas primarias son elegibles para recibir sellantes **GRATIS** (no cobramos a Medicaid o aseguranza privada). Un profesional dental revisara las muelas de su niño(a) para decidir cuales muelas necesitan sellantes. Los sellantes seran aplicados por un higienista dental licenciado por el estado. Todo el personal dental utiliza los procedimientos recomendados para el control de infeccion. Si su niño/a ha participado en este programa anteriormente, por favor inscribalo(a) de nuevo, como este es un programa que continua, los sellantes seran aplicados/reaplicados tal como sea necesario, porque la proteccion anti-caries solamente es possible cuando el sellante esta presente. **El programa de los sellantes no toma el lugar de examines dentales regulares.**

Se les mandara con su niño(a) una nota que explicara:

1. Cuantos sellantes recibieron y la fecha en que fueron aplicados ó;
2. Por que no recibieron sellantes ó;
3. Si sospechamos que su niño(a) tiene caries ó alguna otra condicion que require los servicios adicionales de un dentista, le daremos una recomendacion. En condados selectos, nuestra trabajadora social dental se comunicara con usted para asistirle en obterner servicios dentales.

IMPORTANTE

A la Oficina de Salud Oral se le require por ley que protega la privacidad de la informacion de salud que obtenemos para este servicio. Esta ley se llama Privacidad de las Practicas de Salud, si usted tiene preguntas sobre esta ley, favor de llamar a la Oficina de Salud Oral.

La Oficina de Salud Oral necesita su permiso para revisar los dientes de su niño(a) y para poner los sellantes dentales. Por favor complete el formulario adjunto y regreselo a la maestra(o) de su niño(a) mañana. "SI" debe estar marcado ye el formulario firmado. Si prefiere que su niño(a) no participe, favor de marcar "NO", escriba el nombre de el niño(a), las iniciales suyas, y regrese el formulario a la maestra(o).

GRACIAS

PUBLIC HEALTH DIVISION
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New Mexico Department Of Health
Office of General Counsel
1190 St Francis Dr.
PO Box 26110
Santa Fe, NM 87502-6110

Para recibir una copia de este documento en español, Usted puede pedírselo al Oficial de Privacidad.

NEW MEXICO DEPARTMENT OF HEALTH

NOTICE OF PRIVACY PRACTICES

Effective Date April 14, 2003

"New Mexico is a healthy place in which to live and grow."

Notice of Privacy Practices

Your Privacy Matters to Us

NEW MEXICO DEPARTMENT OF HEALTH

The New Mexico Department of Health keeps your confidential health information safe.

What kinds of information do we collect?
We may collect some or all of the following information about you – your name, address, birth date, some financial information and information about your health. We may also ask you for your medical history, medications you may be taking and any health problems you may have, for the purpose of providing quality health care services.

What do we do with this information?
We use information about you to help in your treatment. The people taking care of you may discuss your information with others who are also involved in your health care. We may also share some of your information to receive payment or to help us in providing quality health care.

Who else can see your information?
We can release information about you if it is necessary to prevent or control the spread of a disease. We may have to give information to the police or to the courts if we are ordered to do so.

What are your rights?
You have the right to see your medical information and to receive a copy. We may charge you for making copies. If you think there are mistakes in your information, you can ask us to make corrections. You have the right to know with whom we have shared your information in accordance with applicable privacy laws. You can ask us not to share certain parts of your medical information.

What do you do if you have a complaint?
If you think your privacy rights have not been respected, you may write to the New Mexico Department of Health Chief Privacy Officer, Office of General Counsel, at P.O. Box 26110, Santa Fe, NM 87502-6110, or you may file a complaint with the Office of Civil Rights, Region VI, U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202. Should you ever file a complaint, it will not be held against you or any member of your family.

For more information, please read the rest of this brochure, "Notice of Privacy Practices."

Thank you.

"New Mexico is a healthy place in which to live and grow."

Your Privacy Matters to Us

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you are a person with a disability and you require this Notice in an alternative format or require a special accommodation to understand this form, you may request assistance from staff at any DOH location or from the DOH Chief Privacy Officer.

How the New Mexico Department of Health May Use or Disclose Your Health Information

Treatment
The people who provide health care services to you will use information about you to determine how best to care for you. We may share health information about you to provide the services you may need, such as physical examinations, nutritional services, medications and prescriptions or hospitalization. We also may disclose health information about you to people outside the New Mexico Department of Health (NM DOH) who may be involved in your medical care, such as family members, physicians or others who provide part of your care.

Payment
NM DOH may share information about you for payment of our services from your health plan or insurance company. For example, we may need to give your health plan information about a clinical exam or immunizations you received (or your child received) so your health plan will pay us or pay you back for the treatment or services we provided. We may also tell your health plan or insurer about a treatment you are going to receive so they can approve it and agree to pay for the treatment.

Health Care Operations
We may use your health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may combine health information about many patients to decide whether additional services should be offered, what services are not needed and whether certain new treatments and services are effective. We may share information with doctors, nurses, technicians, medical interns and other DOH staff for review and learning purposes. We may combine the health information we have with health information from other care providers to compare how we are doing and to see where we can make improvements in the care and services we offer. Sometimes we will remove your name from information so others may use it to study our health care services.

Appointment Reminders and Information
We may call or write to you to remind you that you have an appointment for treatment or medical care. We may tell you about health-related benefits or services that may be of interest to you.

Facility Directory
We may include some information about you in a patient directory for a DOH facility or hospital while you are a patient at the facility or hospital. This may include your name, location in the facility or hospital and, in some cases, your general condition. The directory information about you may also be given to visitors who ask for you by name.

Individuals Involved in Your Care or Payment for Your Care
We may give information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. If you are receiving treatment and services in a DOH facility or hospital, we may also tell your family or friends involved in your care about your condition.

Veterans and Specialized Government Functions
If you were a member of the armed forces, we may release health information about you as required by the Veterans' Administration authorities. We may also release information about you for specialized functions, such as security and military activities.

As Required by Law
We will share health information about you when required to do so by federal, state or local law.

Public Health Risks
We will share health information about you for public health reasons as required by federal or state law:

- To prevent or control disease, injury or disability;
- To report child abuse or neglect;
- To report reactions to medications or other problems with products;
- To notify people of recalls and defects concerning products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for catching or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient or client has been the victim of abuse, neglect or domestic violence;
- To avert a serious threat to health or safety.

Health Oversight Activities
We may share health information for accreditations, audits, investigations, inspections, and licensure. This is necessary for the government to monitor the health care system, government programs and laws.

Lawsuits and Other Disputes
If you are involved in a lawsuit or other legal dispute, DOH may share health information about you in response to a court or administrative order. We may also share health information about you in response to a subpoena or other lawful process by someone else involved in the dispute. We will only do so if you have been told about the request and you have had the chance to obtain an order protecting the information requested.

Law Enforcement
We may share information about you if asked to do so by a law enforcement official, subject to federal and state laws and regulations:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at NM DOH location; and
- In emergency circumstances to report a crime, the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Medical Investigators, Coroners and Funeral Directors
We may give health information to the medical investigator or authorized coroner. For example, such a disclosure may be necessary for identification of a deceased person, or to determine the cause of death. We may release health information to funeral directors as necessary for them to carry out their duties.

Inmates
If you are an inmate of a correctional institution, or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This may be necessary for the institution to provide you with health services, to protect your health or safety or the health and safety of others, or for the safety and security of the correctional institution.

Other Uses Of Health Information
We will not use or share health information about you for any other reason without your written permission. You understand that we cannot take back any disclosures we have already made with your permission, and that we are required to keep our records of the care that we provided to you.

Your Rights Regarding Your Health Information

Right to Inspect and Copy
You have the right to see and receive a copy of the health information we have about you. To inspect and request a copy of your health information at a single DOH location, you may contact that location and ask for assistance from that location's Local Privacy Officer. If you want to see your health information that may be in more than one DOH location, or if you are unsure, you must write to the DOH Chief Privacy Officer. If you ask for a copy, we may charge you for the costs of copying and mailingthe information to you. We may deny your request in special circumstances. If we deny your request to see your health information you may ask us why and ask for a review of our decision. A licensed health care professional chosen by us will review your request and the denial. The person who reviews the denial will not be the same person who originally denied your request. We will do whatever the reviewer recommends.

Right to Request a Correction to Misinformation
If you feel that health information we have about you is not right or is incomplete, you may ask us to correct it (called asking for an amendment). You have the right to ask for a correction for as long as the information is kept by or for DOH. To ask for a correction, you must write to the DOH Chief Privacy Officer. You must give us a reason that supports your request. We may deny your request for a correction if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to correct information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the corrections;
- Is not part of the health information kept by or for us; or
- Is correct and complete.

Right to an Accounting of Certain Disclosures
DOH maintains an accounting of certain disclosures of your health information. You may request an accounting of those disclosures by writing to the DOH Chief Privacy Officer. Your request must state a time period, which may not be longer than six years, and may not include disclosures made before April 14, 2003. Tell us how you want the accounting (for example, on paper or by e-mail). We will give you one accounting per year for free. We may charge you for the accounting if you make more than one request in a 12-month period. If there is a charge, we will tell you what it is and you can decide to take back your request.

Right to Request Restrictions and Withdraw Restrictions
You have the right to request that we limit the health information we share about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a treatment or prescription you received. We do not have to agree to your request. If we do agree, we will do what you ask us to do unless the information is needed to provide you emergency treatment. To ask for limits or restrictions on your health information from a DOH location where you are currently receiving treatment, request assistance from that DOH location's Local Privacy Officer. If you ask for limits or restrictions on your health information that may be at more than one DOH location, or if you are unsure, you must write to the DOH Chief Privacy Officer telling us:

- What information you want to limit; and
- To whom you want the limits to apply (for example, disclosures to your spouse).

If you have requested a restriction to limit the health information we use or share, and we have agreed to that restriction, you have the right to withdraw that restriction by writing to the DOH Chief Privacy Officer.

Right to Request Confidential Communications
You have the right to ask that we communicate with you about your health information other than by mailing that health information to you, or to ask that we send communications to you about your health information to the address you request. We will grant your request if possible.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice at any time by asking for one at any DOH office or treatment location. You also may get a copy of this notice at our website, www.health.state.nm.us.

Complaints
If you believe your privacy rights have been violated, you may complain to the DOH Chief Privacy Officer, or you may file a complaint with the Office of Civil Rights, Region VI, U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202. Should you ever file a complaint, it will not be held against you or any member of your family.

Additional Information
If you have questions regarding this notice, for further information, or to write to the DOH Chief Privacy Officer, contact:

Chief Privacy Officer
Office of General Counsel
New Mexico Department of Health
P.O. Box 26110
Santa Fe, New Mexico 87502-6110

Information About This Notice
We may change this notice at any time. We may make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will display a copy of the current notice in our treatment sites. The notice will show the effective date on the first page. Each time you come to a DOH facility for treatment or health care services, you may ask for a copy of our current Notice of Privacy Practices. If we change our notice, we will provide the revised notice to you. The revised notice will be available in all of our treatment locations and on our web site.

"New Mexico is a healthy place in which to live and grow."

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