Today's Date _____

UAMS Delta Dental of Arkansas Foundation Oral Health Clinic
Patient Registration Form

(Please Print)

Patient Information:

Name _____ **Male** or **Female**
First Middle Last

Date of birth _____ **SSN** _____ **Referred by** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home # _____ **Work #** _____ **Cell #** _____ **Email** _____

Employer _____ **Address** _____

Responsible Party Information:

Spouse's/Parent's Name (circle one) _____

Date of birth _____ **SSN** _____ ☐ **Responsible party is policy holder for patient**

Employer _____ **Phone Number** _____

Nearest relative not living with you _____

Relationship _____ **Phone Number** _____

EMERGENCY CONTACT _____

Phone Number _____ **Relationship** _____

Insurance Information:

Primary Dental Insurance Company _____

Address _____ **Phone Number** _____

Policy Holder _____ **Date of birth** _____ **Group #** _____

Employer _____ **ID #** _____

Secondary Dental Insurance Company _____

Address _____ **Phone Number** _____

Policy Holder _____ **Date of birth** _____ **Group #** _____

Employer _____ **ID #** _____

Today's Date:_____

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Physicians & Medications

Please list all treating physicians, including your primary care provider (PCP) and contact info, including: name, address, and phone number.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please list all medications you are currently taking, including dosage and frequency.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

UAMS
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

AUTHORIZATION to TAKE and RELEASE
PATIENT PHOTOGRAPHS or VIDEO/AUDIO RECORDINGS

FOR STAFF TO COMPLETE BEFORE PATIENT SIGNS: **Dept/Clinic Name**_____ **and Slot #**_____

Person Making Photo/Recording _____ **Date Taken**_____ **(for initial photo/recording)**

(check all that apply) ___**Photographs** ___**Video Recordings** ___ **Audio Recordings**

Description:_____
Location where image will be stored: _____

I, _____ hereby consent to the taking of photography, audio/visual recordings or other images of
Print Patient Name
me by UAMS. I understand that my photographs, videotapes, digital or other images may be used to assist with my identification, diagnosis and treatment and the payment of my bill. These images may also be used for UAMS Health Care Operations such as performance improvement and educational purposes within UAMS. I also give my permission and authorize UAMS** to make and **DISCLOSE** photographs or recordings described above to the public for educational, commercial, or other purposes as follows:
(PATIENT: Please strike through and initial any of the disclosures you are not authorizing, if any).

1. UAMS internet website(s);
2. UAMS Posters, UAMS Publications, UAMS Photograph Books (by, on behalf of, or about UAMS);
3. Media, Internet Websites, Publications (TV, newspaper, magazine, any other media or websites outside UAMS); and
4. Healthcare-Related Presentations, Publications, Seminars, Conferences and Meetings (within and outside UAMS).
5. Other disclosures authorized, if any _____

Additional Health Information Disclosed. I understand and agree that any photographs/recordings authorized by me may also disclose my Protected Health Information related to my **treatment, condition, procedure, surgery** or other Protected Health Information associated with the photographs or video/audio recordings, and **I authorize this disclosure.**

UAMS is **not** receiving direct or indirect compensation for use/disclosure of the photograph/recordings described in this Authorization.
Expiration Date – This Authorization expires **two years** from the date I sign the Authorization, or after the photographs and recordings are no longer needed by UAMS for the use and disclosure that I have authorized, whichever date is later.
Withdrawal of Authorization – I understand that I am not required to sign this Authorization. If I sign this Authorization, I may revoke/withdraw the Authorization at any time by giving written notice to UAMS [Dept/Clinic Above] Slot # [above], 4301 W. Markham, Little Rock, AR 72205. A withdrawal of this Authorization will not apply to records, information, photographs, audio/visual recordings or other information already used/released in reliance upon the Authorization. A photocopy or faxed copy of this signed Authorization shall constitute a valid authorization. **During the recording/filming, I have the right to stop recording/ filming at any time.**
Release of Liability – I agree that UAMS, including its governing Board, physicians, agents and employees, are hereby released from legal responsibility or liability for the access and release of my information to the extent indicated and authorized herein.
Re-Disclosure – I understand that once the above information is disclosed, it may no longer be protected by privacy laws.
UAMS will not condition treatment, payment, enrollment or eligibility for benefits on your signing of this Authorization.
****If patient is a patient of Arkansas Children's Hospital (ACH) , the terms of this Authorization also include and extend to ACH.**

Signature of Patient or Legal Representative_____ Date_____
Patient Date of Birth and/or Medical Record Number For Identification Purposes: _____
If Legal Representative has signed on behalf of Patient, state the authority of Legal Representative to do so:
_____
(*such as parent of a minor, court-appointed guardian, appointed in a Power of Attorney*)

Office Staff: Provide Copy of Signed Authorization to Patient/Legal Representative

University of Arkansas for Medical Sciences Delta Dental of Arkansas
Foundation Oral Health Clinic

PATIENT NAME _____ **DATE OF BIRTH** _____

GENERAL CONSENT FOR TREATMENT

I consent to dental care and treatment for the patient named above at the University of Arkansas for Medical Sciences Delta Dental of Arkansas Foundation Oral Health Clinic ("OHC" or "Clinic"). I understand and agree the practice of dentistry is not an exact science and there is no guarantee any particular treatment will be successful. I understand that during treatment, it may be necessary to change or add procedures because of conditions that were not present during examination, but were found during the course of treatment. I understand there are risks associated with dental care including, but not limited to: aspiration, pain, excessive bleeding, cardiac arrest, discoloration and injury to blood vessels and nerves, and temporary or permanent nerve damage. I understand the OHC is part of a teaching facility and agree residents and others in training programs may be involved in my care and treatment under the supervision of licensed dentists and hygienists. I understand I have the right to consent or refuse any proposed procedure or treatment.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

In consideration of services rendered, I hereby assign any benefits due under my insurance coverage to the OHC. I understand I am financially responsible for all charges not covered including deductibles, co-pays, and co-insurance. I understand I am responsible for payment prior to the time of service, and after reasonable notice, any balances not paid may be turned over to a collection agency and/or attorney, and I will be responsible for any related attorney's fees, costs of collection and court costs. I understand the OHC will provide an estimate of the cost of my treatment plan as a courtesy, but actual costs could be more or less depending on any benefits provided by my insurance company or if additional treatment is required. I understand it is my responsibility to comply with all pre-authorization requirements of any insurance or dental coverage plan that is relied on for coverage. I agree the OHC, their designated collection agency, attorney or other authorized designee on behalf of the OHC may contact me on my cell phone, land line or any other number I provide, directly, through an automated dialing system or through an artificial or prerecorded voice system to discuss payment of any unpaid financial obligation I have at the OHC or to receive general information, and this consent shall remain valid until expressly revoked.

RELEASE OF INFORMATION AUTHORIZATION

I understand my protected health information will be released in accordance with the UAMS Notice of Privacy Practices. I acknowledge I have received a copy of the UAMS Notice of Privacy Practices on this or a prior occasion.

I understand I may grant permission for the OHC to share my dental or billing information with a family member or friend involved in my care, who is not otherwise authorized by law to act on my behalf, by filling out the information below. I understand I am not required to grant this permission. This authorization will remain valid unless revoked in writing by the patient or legal representative.

Name_____Relationship_____Phone #_____
Name_____Relationship_____Phone #_____
Name_____Relationship_____Phone #_____

SIGNATURE _____ DATE _____
Patient or Legal Representative and Relationship

DELTA DENTAL OF ARKANSAS FOUNDATION ORAL HEALTH CLINIC

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

UAMS Delta Dental of Arkansas Foundation Oral Health Clinic

Patient Information

The UAMS Delta Dental of Arkansas Foundation Oral Health Clinic (OHC) is part of the College of Health Profession's Center for Dental Education. The OHC is a General Dentistry Practice designed to provide clinical education and experience to its residency program. Because teaching and education is a primary responsibility of this clinic, our operations differ somewhat from the typical private dental practice.

What does this mean for you?

- You may be asked to change your appointment time or date due to changes in the residency schedule. Our residents often have lecture or clinic changes due to their curriculum requirements.
- We have many patients who are awaiting life-saving chemotherapy, radiation, or transplant treatment and need dental clearance from us in order for these treatments to be started. Please understand if we ask you to make a change in your appointment, it could be to save a life.
- With the increasing number of dentists in our program, it is important that if you have a preferred provider, you let us know your preference when scheduling your appointment. Once you establish care with one of our dentists, it is customary that you remain with that dentist in order to have continuity of care.
- We teach comprehensive care through our residency program. In order to be a patient and remain a patient of the OHC, all work must be completed here once care has been established, unless an outside referral is required.

Other things to note:

- We are not connected to the main hospital 'mychart' system. The appointments you make in our clinic will not show up under the 'my appointments' section of your 'mychart' account.
- We are not in the hospital's electronic medical record (EPIC) at this time. Therefore, we need all current medications and physician information before we can treat you.

Thank you for choosing UAMS for your dental care needs. Please read the patient information below and keep for your records.

New Patients

The OHC complies with all Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or gender. If you require special services please inform our staff. New patients over the age of 18 years will receive a comprehensive evaluation including, but not limited to: review of medical history, extra/intra-oral examination, and appropriate radiograph(s) as determined by the individual's needs, oral hygiene instructions and individualized patient information on oral health status, diagnosis, and any subsequent treatment needs. All treatment will be rendered under the supervision of a licensed dentist in accordance with standards recognized by the dental and dental hygiene profession. Please arrive 20 minutes prior to the start of your first dental appointment to allow completion of patient registration and medical history forms. You will need to bring a photo ID along with your dental insurance information, if any.

Children and Minors Under 18

New patients who are under the age of 18 will need to have their medical history and consent for treatment completed by a parent or guardian prior to treatment. Children cannot be left unattended in the clinic area and must be accompanied by a responsible adult at all times.

X-Rays

X-rays (dental radiographs) are a necessary part of your diagnosis and treatment. Current radiographs are recommended for all patients. The type of radiographs prescribed by the dentist will be based upon your individual needs. If you decline to have x-rays taken or to provide current radiographs from your previous dentist's office, it may prevent us from accurately assessing your dental condition and rendering appropriate treatments. Previous radiographs can be mailed to us or transferred electronically by your previous dentist at your request, but additional x-rays may be needed if you are experiencing new symptoms or the images are not current or are of poor quality. You are responsible for arranging for transfer of your dental records prior to your first scheduled appointment in the OHC. In the event you need x-rays taken at the OHC to be sent to another dentist, we can accommodate your request for a $15.00 duplication fee.

Infection Control

For your protection, all dental instruments are sterilized and dental units are disinfected after each patient. Residents and faculty are required to wear masks, gloves, and glasses during patient treatment. The OHC maintains the infection control guidelines set forth by the Centers for Disease Control and Prevention (CDCP) and the Occupational Safety and Health Administration (OSHA).

Appointment Keeping

We recommend that you be seen at least once every six months for standard evaluation and dental care. Please arrive for your appointment on time. If you arrive late, your appointment may be rescheduled. If you are unable to keep your appointment time, please provide 24-hours notice by calling 501-526-7619. If you do not appear for your appointment or cancel in under 24 hours it will be considered a *failed appointment.* If the first scheduled appointment is failed, another appointment will not be made. Should you consistently miss appointments, you may be dismissed as a patient. Patients are to park in the UAMS Patient and Visitor

Dental Insurance

As a courtesy, the OHC will file dental insurance claims and help you estimate your portion of the cost for the treatment based on information you provide to us. This is not a guarantee of coverage, and the OHC is not responsible for any insurance claim denials. You are financially responsible for any charges not covered by your insurance, including deductibles, co-pays, and co-insurance. Please remember to promptly notify the clinic if your insurance plan changes.

Cellular Phones

As a courtesy to our staff and other patients, we ask that you refrain from making or receiving phone calls or text messages while in the treatment areas. Please turn your phone off or place on mute while receiving dental treatment.

Photography and Video

Photography and video is frequently employed to assist in the diagnosis of certain dental conditions. The gathering of diagnostic images for clinical care and treatment is considered a part of your general consent for treatment. However, certain clinical situations may present the opportunity to document procedures for purposes of education, including publications in professional journals or books. Because we are a teaching institute, you may be asked to sign a separate consent that will allow us to take and release photographs and video/audio recordings of your clinical care for teaching purposes outside of the OHC. You may decline to consent to these photographs and recordings. If you decline, you will still be able to receive treatment at the OHC, and you will not be penalized in any way.

Medical History

If you have a history of any medical conditions or are taking any medications, it is very important that you disclose this information to your dentist so an appropriate plan of care can be developed to reduce risks of complications based on your current medical condition. For your safety, you will be asked to complete a detailed medical history form so the dentist will be aware of your medical history and can develop an appropriate treatment plan or take any needed precautions when providing your dental care. It is also your responsibility to provide accurate and up-to-date medical information, including a list of all of your medications and dosages, at each dental appointment. You will be asked to reschedule your appointment if you do not bring all of this information with you.

UAMS

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES

NOTICE OF PRIVACY PRACTICES

Effective Date: April 8, 2013

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.

This Notice is provided on behalf of the University of Arkansas for Medical Sciences including its Medical Center and clinics, Psychiatric Research Institute, Area Health Education Centers, and other facilities ("UAMS"). UAMS provides patient care through a healthcare system committed to education and research.

PURPOSE: This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or healthcare operations and for other purposes permitted or required by law. "Protected Health Information" is information that may identify you and that relates to your past, present or future physical or mental health, and may include your name, address, phone numbers and other identifying information.

We are required to give you this Notice and to maintain the privacy of your Protected Health Information. We must abide by this Notice, but we reserve the right to change the privacy practices described in it. A current version of this Notice, with required revisions, if any, may be obtained from the UAMS web site, http://www.uamshealth.com/ and will be posted in prominent areas of our facilities. You may also receive a current copy by sending a written request to the UAMS HIPAA Office, 4301 W. Markham #829, Little Rock, AR 72205.

We understand that medical information about you and your health is personal and confidential, and we are committed to protecting the confidentiality of your medical information. We create a record of the care and services you receive at UAMS. We need this record to provide services to you and to comply with certain legal requirements. This Notice will tell you about the ways we may use and disclose your information. We also describe your rights and certain obligations we have to use and disclose your health information.

If you believe your privacy rights have been violated, you may complain to us or to the U.S. Secretary of Health and Human Services. To file a complaint with us, you may send a letter describing the violation to the UAMS Privacy Officer, 4301 W. Markham #829, Little Rock, AR 72205. There will be no retaliation against you for filing a complaint.

If you have questions or need more information, contact the UAMS HIPAA Office at 501-614-2187.

WHO WILL FOLLOW THIS NOTICE: This Notice describes the practices of UAMS healthcare professionals, employees, volunteers and others who work or provide healthcare services at any UAMS facility, including students-in-training.

ACKNOWLEDGMENT: You will be asked to sign an Acknowledgment of receipt of this Notice. The delivery of your healthcare services will in no way be conditioned upon the signing of this Acknowledgment.

Your Privacy Rights. You have the following rights relating to your Protected Health Information. You may:

- Obtain a current paper copy of this Notice.
- Inspect or obtain a copy of your records, in paper or electronic form. You may be charged a fee for the cost of copying, mailing or other supplies. We are allowed to deny this request under certain circumstances. In some situations, you have the right to have the denial of your request reviewed by a licensed healthcare professional identified by UAMS who was not involved in the original denial decision. We will comply with the outcome of this review.
- Request that we amend your record, if you feel the information is incomplete or incorrect. We are allowed to deny this request in certain circumstances and may ask you to put these requests in writing and provide a reason that supports your request.
- Request in writing a restriction on certain uses and disclosures of your information. We are not required to agree to the requested restrictions, unless you are requesting to restrict certain information from your health plan and you have paid for your UAMS services in full.
- Obtain a record of certain disclosures of your Protected Health Information.
- Make a reasonable request to have confidential communications of your Protected Health Information sent to you by alternative means or at alternative locations.
- Provide us with written permission for uses and disclosures of your Protected Health Information that are not covered by the Notice or permitted by law. Except to the extent that the use or disclosure has already occurred, you may cancel this permission. This request to cancel must be put in writing.
- Submit any written requests to inspect, copy or amend your records to the UAMS Health Information Management Department.

Our Responsibilities. We are required to protect the privacy of your Protected Health Information, abide by the terms of the Notice, and make the Notice available to you. We are also required to notify you if a breach of your health information occurs.

Examples of Uses & Disclosures

We will use your Protected Health Information for treatment. Certain information obtained by a nurse, doctor, therapist, or other healthcare worker will be put into your record and used to plan and manage your treatment. We may provide reports or other information to your doctor or other authorized persons who are involved in your care, including healthcare providers outside of UAMS We may make your protected health information available electronically through an electronic health information exchange to other health care providers and health plans that request your information for their treatment and payment purposes. Participating in an electronic health information exchange may also let us see their information about you for our treatment and payment purposes.

We will use your Protected Health Information for payment. A bill will be sent to you and/or your insurance company with information about your diagnosis, procedures and supplies used. We may also disclose limited information about your bill to others, such as a collection agency, to obtain payment.

We will use your Protected Health Information for regular healthcare operations. UAMS may use your Protected Health Information to check on the care you received, how you responded to it, and for other business purposes related to operating the hospital or clinics. UAMS is a teaching facility, and information about you may be shared with students and trainees for teaching purposes.

Business Associates: We may share some of your Protected Health Information with outside people or companies who provide services for us, such as typing physician reports.

Patient Directory: Unless you tell us not to, we may disclose your name, location in the facility, and general condition to people who ask for you by name. If provided by you, your religious affiliation may also be given to members of the clergy.

Notification: We may use or disclose your Protected Health Information to notify a family member or other person involved in your care, your location and general condition unless you tell us not to do so.

Communication with family: We may share your Protected Health Information with a family member, a close personal friend, or a person that you identify, if we determine they are involved in your care or in payment for your care, unless you tell us not to do so.

Research: Your Protected Health Information may be used for research purposes in certain circumstances with your permission, or after we receive approval from a special review board whose members review and approve the research project.

Coroners, Medical Examiners, Funeral Directors: In the event of your death, we may disclose your Protected Health Information to these people, to the extent allowed by law, so that they may carry out their duties.

Organ Donor Organizations: We may share your Protected Health Information with the organ donation agency for the purpose of tissue or organ donation in certain circumstances and as required by law.

Contacts: We may contact you to provide appointment reminders or to tell you about new treatments or services.

Fundraising and Marketing: We may contact you as part of UAMS fundraising or marketing efforts. You have a right to opt out of Fundraising communications and may do so by calling 1-888-995-UAMS (8267) or emailing advancement@uams.edu.

Food and Drug Administration (FDA): We may share your Protected Health Information with certain government agencies like the FDA so they can recall drugs or equipment.

Workers Compensation: We may disclose your Protected Health Information for workers' compensation claims.

Public Health: We may give your Protected Health Information to public health agencies who are charged with preventing or controlling disease, injury or disability and as required by law.

Communicable Disease: We may disclose your Protected Health Information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition, if authorized by law to do so, such as a disease requiring isolation.

Correctional Institution: If you are an inmate of a correctional institution, we may disclose your Protected Health Information to the institution or law enforcement as needed for your health or the health and safety of others.

Law Enforcement: We must disclose your Protected Health Information for law enforcement purposes as required by law.

As Required by Law: We must disclose your Protected Health Information when required by federal, state or local law, such as to report gunshot wounds.

Health Oversight: We must disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as investigations and inspections. Oversight agencies are those that oversee the healthcare system, government benefit programs, such as Medicaid, and other government regulatory programs.

Abuse or Neglect: We must disclose your Protected Health Information to government authorities that are authorized by law to receive reports of suspected abuse or neglect involving children or endangered adults.

Legal Proceedings: We may disclose your Protected Health Information in the course of any judicial or administrative proceeding or in response to a court order, subpoena, discovery request or other lawful process, as allowed by law.

Required Uses and Disclosures: We must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the HIPAA Privacy Regulations.

To Avoid Harm: We may use and disclose information about you when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.

For Specific Government Functions: In certain situations, we may disclose Protected Health Information of military personnel and veterans. We may disclose your Protected Health Information for national security activities required by law.

Sale of Information: UAMS will not sell your information without your prior written authorization or as otherwise allowed by law.