Dental Care Coordination
Consent for Dental Care

Dental3 is working with your child's school to provide free dental care coordination. With your consent, we will help you find dental care in your community. Please complete the form below so we can begin getting your child the help they need right away.

Name of Child: _____
(Last) (First) (Preferred Name)

Child's Date of Birth (mm/dd/yy):_____ Grade: _____School: _____

Contact Information	
Parent/Guardian Name:	
Best phone number to reach you:	Permission to Text: ☐ Yes ☐No
Email address:	
Mailing address:	
Language spoken at home:	

Please provide the following information so we can better serve your child:

My child is experiencing (check all that apply):

☐ Pain ☐ Swelling ☐ Bleeding ☐ Mouth Sores ☐ Discomfort ☐ Broken Tooth ☐ Other _____

My child is taking (list medications):	None: ☐
My child is allergic to:	None: ☐
Any current medical problems:	None: ☐
Any behavioral considerations:	None: ☐
Other information to help us better serve your child:	None: ☐

Please complete the section below. You will not receive a bill.

Health Insurance: ☐ Oregon Health Plan (OHP) / Medicaid ID# _____ ☐ Private dental insurance company _____ ☐ No health insurance	Care Coordination for your family is free. You will not receive a bill.

By signing below you:

As the legal parent/guardian, I hereby consent to the release and exchange of information, including any relevant personal health information, between the Dental3 and Collaborating partner providers, school staff, insurance carriers, the child's dentist, applicable Coordinated Care Organization, and/or the Dental Care Organization of record. I have received a copy of "Notices of Privacy Practices." Privacy Practices are available on the Dental3 website http://dental3.net/forms/.

Parent/Guardian Signature: _____ Date: _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The confidentiality of your protected health information, also called your medical record, is a high priority at Dental 3. There are a number of reasons we may need to use this information or disclose it to others. This Notice of Privacy Practices is provided to inform you of the ways we can use and release information from your medical record. THIS PAGE IS NOT THE FULL NOTICE OF PRIVACY PRACTICES. The full notice is available upon request. In addition to our longstanding commitment to protecting your information, there are certain obligations we have under federal law. One of those obligations is to provide you with this Notice.

THINGS EXPLAINED IN THE FULL NOTICE OF PRIVACY PRACTICES

- **How we may use and share your health information without your permission to:**
  - Provide treatment to you
  - Get paid for the services we provide to you
  - Make reports to federal, state, and local agencies and others when the law requires such reporting
  - Make reports or share information for public health, safety, and/or research purposes.

- **How we can share your information without your permission, but only if we give you a chance to object:**
  - To share information about you to family, friends, or others involved in your care for payment for the services you receive
  - To share information in case of a disaster to let your family and friends know where you are and your general condition

- **How we can use and share your medical information only with your permission for disclosures other than those described above.**

- **Your legal rights under federal privacy laws include your right to:**
  - Ask to see and copy your medical information
  - Ask that incorrect or incomplete information in your medical information be corrected
  - Ask for a list of the places we have sent your information unless it was sent with your permission, for payment, treatment, or health care operations
  - Ask that we limit the information we use or share for treatment, payment, or healthcare operations, or the information we share with family members or others involved in your care. We are not required to agree to your request
  - Ask that we communicate with you in a confidential manner
  - Ask for a paper copy of the Notice of Privacy Practices at any time
  - Be notified in the event of a breach of unsecured, protected health information
  - File a complaint if you think your privacy rights have been violated
  - Pay out of pocket in full for a healthcare item or service and restrict disclosure of that particular item or service to your health plan provider