The Arc
of Florida

For people with intellectual and developmental disabilities

agency for persons with disabilities
State of Florida

Dear Applicant,

The Arc of Florida is a 501c (3) non-profit organization, serving individuals with intellectual and developmental disabilities throughout the State of Florida. The Arc of Florida has received a legislative appropriation to directly pay dentists for preventive and acute dental services for this population. The Legislature has approved, the Governor signed into law, and the Agency for Persons with Disabilities (APD) has contracted to pay for this program.

Individuals on the APD waitlist for services and those on the iBudget Waiver are eligible to receive dental services through The Arc of Florida Dental Program. If there are funds in your iBudget waiver cost plan for limited dental, you can still be eligible for this funding. The Arc of Florida, along with the help of your local APD regional office and local Arc chapter, identified you as an individual who may be in need of dental services.

The Arc of Florida has provided you with an application that will need to be filled out, signed and returned to us through one of the following ways:

- Fax: 850.921.0418
- Email: dental@arcflorida.org
- Mail: The Arc of Florida
  Attn: Dental Services Program
  2898 Mahan Drive Suite 1
  Tallahassee, Florida 32308

Our priority is to serve individuals who are in immediate pain. Due to high frequency of submissions it may take between 30-60 days to process and approve your application. Once approved, we will immediately contact you. We are able to sometimes provide for routine dental services. We make these decisions based upon the number of dental applications we receive for more immediate dental needs. Please be aware that we must verify and first use any dental insurance you currently have for dental care before accessing these funds.

If you have questions, please call The Arc of Florida Dental Services Program at 1.855.322.6735.
We look forward to serving you.

Sincerely,

Deborah J. Linton
Chief Executive Officer, The Arc of Florida

Dental Services Program Reference Guide Sheet

How The Arc of Florida Dental Services Program Works:

- The Arc of Florida maintains a list of dentists and dental schools who are willing to provide dental services for individuals with intellectual and/or developmental disabilities (I/DD).
- The Arc of Florida pre-screens your application to determine if you are eligible to receive funding for services based on the requirements of The Arc of Florida contract.
- Once approved, The Arc of Florida will notify you of eligibility and if needed, you will be given a referral list of dentists in your area willing to provide dental services. We encourage you to visit https://appsmqa.doh.state.fl.us/MQASearchServices/Home to review any dentist you may be interested in using to see if there have been any previous disciplinary actions against them.
- It is either your or your caregiver/family member/ Support Coordinator's responsibility to notify The Arc of Florida as to which dental provider you would like to use **before making an appointment**.
- The Arc of Florida will contact the dental provider to let them know that The Arc of Florida will pay for your visit.
- It is either your or your caregiver/family member/Support Coordinator's responsibility to schedule the appointment with the dental provider and to notify The Arc of Florida of when the appointment will take place.
- After the appointment, you or the dental provider will need to fax or mail the dental treatment plan to The Arc of Florida.
- The Arc of Florida will notify you or your caregiver/family member/Support Coordinator in writing whether additional dental services are approved or not approved.
- For any additional visits after the initial visit, you or your caregiver/family member/Support Coordinator will need to make the appointment with the dental provider as well as notify The Arc of Florida as to when the appointment is, in order for The Arc of Florida to arrange payment with the dental provider. This step will repeat for each appointment until all approved services have been completed.
- The Arc of Florida will pay for all services approved in writing by our office. Payment method and amount will already have been discussed with the dental provider prior to services being rendered.

The Arc of Florida has approved the following methods of contact:

- Fax: 850.921.0418
- Email: dental@arcflorida.org
- Mail: The Arc of Florida
  Attn: Dental Services Program
  2898 Mahan Drive, Suite 1
  Tallahassee, FL 32308

PLEASE KEEP THIS FORM FOR YOUR RECORDS

The Arc of Florida

Revised 05/2016

Dental Services Program Application

You must complete the application AND attachments AND return all documents.

First Name: _____ Last Name: _____ Date: _____

Date of Birth (MM/DD/YY): _____ Social Security Number: _____

Address: _____ City: _____ Zip: _____

County: _____ Phone: _____ Gender: Male ☐ Female ☐

Caregiver Name (If applicable): _____

Caregiver Relation: _____ Caregiver Phone: _____

Waiver Support Coordinator (WSC) (If applicable): _____

WSC Phone: _____ WSC Email: _____

Primary Contact: Yourself ☐ Caregiver ☐ Waiver Support Coordinator ☐

Please fill out the questions below to the best of your ability

Have you received services from The Arc of Florida Dental Services Program before? YES ☐ NO ☐

Are you able to communicate verbally? YES ☐ NO ☐ Is your preferred language Spanish? YES ☐ NO ☐

Are you on the Community Based Medicaid Waiver (iBudget)? YES ☐ **OR** Are you on the Agency for Persons with Disabilities Waitlist? YES ☐ **OR** Neither one of these? YES ☐

Have you applied for employment services from Vocational Rehabilitation? YES ☐ NO ☐

Do you have funding in your iBudget (Waiver funding) to cover dental care? YES ☐ NO ☐

If YES, how much funding? _____

Do you currently have dental insurance? YES ☐ NO ☐

Do you have a Pooled Trust, Special Needs Trust, or ABLE Account? YES ☐ NO ☐

If you currently have a dentist, please give their name and number:

Dentist Name: _____ Phone: _____

Do you have a Dental Treatment Plan? YES ☐ NO ☐ If Yes, Please attach with application.

When was the last time you went to see a dentist: _____

Are you currently experiencing dental pain? YES ☐ NO ☐

If so, please describe your pain: _____

Do you require sedation? YES ☐ NO ☐

The Arc of Florida will contact you for additional information.

The Arc of Florida

Agreement for Referral for Dental Services

This agreement is made between The Arc of Florida, Inc. ("Arc") and _____, ("Recipient").

Request for Funding: Recipient has requested that Arc provide funding for dental services for him/her. Amount of services to be paid by Arc depends on cost of services needed, dental provider rates, and treatment plan. Arc is only obligated to pay those services pre-approved in writing by The Arc and services that are rendered and subjected to the terms and conditions of Arc's contract with the Agency for Persons with Disabilities, (APD). Upon Recipient receiving approved dental services, Arc will pay the dentist chosen by Recipient. However, if Recipient incurs costs for services in excess of the pre-approved amount, the excess amount due to the selected dentist is the obligation of the Recipient to pay. All pre-approvals will become void at the end of the state fiscal year, which is June 30th.

Choice of Dentists: Arc has provided Recipient a list of dentists who are participating in the dental program. Recipient is free to choose among any such dentists to obtain the dental services or may request another dentist if Recipient is an established patient elsewhere. Recipient should be aware that Arc has not performed any background checks or engaged in any other means of checking the credentials of such dentists other than verifying that they hold a active dental license with the Florida Department of Health. The Arc of Florida has verified that any dental school listed holds a license with the Florida Department of Health, but Arc has not verified the license of any students or staff employed at the dental school. Arc is providing a list of dentists for the Recipient's convenience and this is not an endorsement in any manner of such dentists. It is acknowledged that Arc is not making any decisions or providing any information on the course or methods of treatment and all such decisions are being made by the applicable dental professional and agreed to by the Recipient. **The recipient receiving dental services or a representative for the recipient must notify The Arc of Florida of their appointment so payment can be arranged. If for some reason the recipient misses their appointment, they will automatically forfeit this funding and will no longer be considered eligible to receive dental services under this contract.**

Disclaimer of Liability: Recipient covenants not to sue Arc for any claims arising out of any personal injuries, property damage, wrongful death, negligent or illegal acts caused by any dentist, or any persons employed by the dentist, or which occur on the premises of the dentist. Recipient agrees to hold Arc harmless for any monetary loss in connection with the dental services received. Recipient acknowledges that the dentist is an independent contractor, and is not in the employ of Arc.

Arbitration: In the event the parties are unable to amicably resolve any claim by Recipient for damages, including gross negligence, regarding any services provided by Arc under this agreement, Recipient agrees that Recipient must submit the dispute to binding arbitration pursuant to the rules of the American Arbitration Association ("AAA"). Each party shall bear its own costs, expenses, and attorney fees. Venue for the Arbitration shall be in Leon County, Florida.

Recipient's Representative: If the undersigned is signing this Agreement as the Resident's legal representative, such person acknowledges that they have the requisite legal authority to bind the Recipient, and will hold harmless and indemnify Arc for any inadequacy in such authority or any matters which arise as a result of signing this agreement under such assertion of legal authority and it is claimed to be in any manner incorrect.

Photo Release *please check one*:

☐ I am giving The Arc of Florida authorization to use, reproduce, and/or publish photographs and/or video that may pertain to me— including my image, likeness and/or voice without compensation. I understand that this material may be used in various publications, public affairs releases, recruitment materials, broadcast public service advertising (PSAs) or for other related endeavors. This material may also appear on The Arc of Florida's website. This authorization is continuous and may only be withdrawn by my specific rescission of this authorization. Consequently, The Arc of Florida may publish materials, use my name, photograph, and/or make reference to me in any manner that The Arc of Florida deems appropriate in order to promote/publicize service opportunities.

☐ I do not want The Arc of Florida to use, reproduce, and/or publish photographs and/or video that pertain to me.

Signed on the date indicated by Recipient or Legal Representative

_____ _____

Recipient of Services or Applicable Legal Representative Date

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize **The Arc of Florida, Inc.** ("Provider") to disclose protected health information ("PHI") regarding:

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____

_____

I authorize the PHI be disclosed at my individual request to the following recipient:

Name: The Arc of Florida, Inc. Physical address: 2898 Mahan Drive Suite 1, Tallahassee, Florida 32308

_____

Telephone number(s): 850-921-0460 Fax number: 850-921-0418 Email address: dental@arcflorida.org

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Check one:

I authorize the following PHI to be released:

___ All health information about the patient in the possession of Provider, including, but not limited to psychiatric, mental health treatment information excluding psychotherapy notes, HIV test results, genetic testing information or alcohol or drug treatment information;

___ For a limited time period beginning _____ and ending _____ all health information about the patient in the possession of Provider, including, but not limited to psychiatric, mental health treatment information excluding psychotherapy notes, HIV test results, genetic testing information or alcohol or drug treatment;

___ Limited PHI about the patient in the possession of Provider to exclude the following information which I request not be disclosed: _____
_____.[i]

___ Other, as described here_____.

I understand and acknowledge the following statements:

1. I may revoke this authorization at any time by notifying the Provider in writing of the revocation, unless the Provider has already relied on this authorization to disclose PHI;
2. PHI disclosed may be subject to re-disclosure and no longer be protected by federal or state privacy laws;
3. I am signing this authorization voluntarily. I may decline to sign this authorization. However, refusal to sign does not stop the Provider's disclosure of PHI that is otherwise permitted to be disclosed by law without my specific authorization;
4. Provider will not condition my treatment on whether I sign, or refuse to sign, this authorization;
5. I will receive a signed copy of this form.
6. I understand that unless otherwise revoked, this authorization will expire one year after the patient is discharged from Provider's care.

Check one:

____ I am the patient and I understand and agree to the provisions of this authorization.

____ I understand and agree to the provisions of this authorization on behalf of the patient named above. I have signed my name individually as the parent of a minor patient OR as the representative of the adult patient and have attached, or previously provided, a copy of the document authorizing me to serve as the patient's legal representative.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Signature of Parent/Legal Representative/Competent Adult (if applicable) Date

_____ _____
Signature of Witness Date

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[i] The Provider is authorized by law to use or disclose PHI for a variety of reasons without the patient's authorization. Please see the Provider's Notice of Privacy Practices for details.

This authorization was developed to comply with the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, the American Recovery and Reinvestment Act of 1009 and associated regulations.

The Arc of Florida, Inc.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Revised as of July 31, 2013

By law, we are required to make available to you a copy of our Notice of Privacy Practices ("Notice"). By signing below you acknowledge that you received, or been offered and declined, a copy the Notice.

A current copy of the Notice is also posted in the office, or is available to you upon request. If the Notice is revised, you may review and obtain the new version at any time.

You may decline to sign this acknowledgement.

I have ❒ received or ❒ declined a copy of the Notice of Privacy Practices.

Patient Name (Print): _____

Signature of Patient or Legal Representative: _____

If Legal Representative, list Relationship to Patient: _____

Date: _____

For Office Use Only

We were unable to obtain this written acknowledgement because:

_____

_____

Initials: _____ Date: _____

THE ARC OF FLORIDA, INC.
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Revised as of May 6, 2016

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 have any questions or wish to receive additional information about the matters covered by this Notice of Privacy Practices ("Notice"), please contact the Privacy Officer for THE ARC OF FLORIDA, INC. ("ARC") DEBORAH LINTON at 2898 MAHAN DRIVE SUITE 1, TALLAHASSEE, FL 32308 or call: 1-800-226-1155.

This Notice is provided to you in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and associated regulations, as may be amended (collectively referred to as "HIPAA") describing ARC's legal duties and privacy practices with respect to your Protected Health Information ("PHI"). ARC is required to abide by the terms of this Notice currently in effect, and may need to revise the Notice from time to time. Any required revisions of this Notice will be effective for all PHI that ARC maintains. A current copy of the Notice will be posted in each office and you may request a paper, or electronic, copy of it.

PHI consists of all individually identifiable information which is created or received by ARC and which relates to your past, present or future physical or mental health condition, the provision of health care to you, or the past, present or future payment for health care provided to you.

USE AND DISCLOSURE OF PHI FOR WHICH YOUR CONSENT OR AUTHORIZATION IS NOT REQUIRED

HIPAA permits ARC to use or disclose your PHI in certain circumstances, which are described below, without your authorization. However, Florida law may not permit the same disclosures. ARC will comply with whichever law is stricter.

1. **Treatment**: ARC may use and disclose your PHI to provide, coordinate or manage your health care related services, including consulting with health care providers about your health care or referring you to a health care provider for treatment. For example, ARC may discuss your health information with your dentist to schedule appointment times and discuss the details of your treatment. ARC may also discuss your services with your waiver support coordinator to ensure that you are receiving the benefits necessary to meet your needs.

2. **Payment**: ARC may use and disclose your PHI, as needed, to obtain payment from Medicaid for services ARC provides to you through the Medicaid Developmental Disabilities Waiver for home and community program. For example, ARC may disclose and receive information about you from Florida Agency for Health Care Administration ("AHCA") and the Agency for Persons with Disabilities ("APD") regarding the type of services you receive.

3. **Health Care Operations**: ARC may use or disclose your PHI in order to carry out its administrative functions. These activities include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualification of health care professionals, business planning and development, business management and general administrative activities. For example, ARC may disclose your PHI to licensing or accrediting agencies reviewing the types of services provided.

4. **Required by Law**: ARC may use or disclose your PHI to the extent that such use or disclosure is required by law.

5. **Public Health**: ARC may disclose your PHI to a public health authority, employer or appropriate governmental authority authorized to receive such information for the purpose of: (a) preventing or controlling disease, injury or disability; reporting disease or injury; conducting public health surveillance, public health investigations and public health interventions; or at the direction of a public health authority, to an official of a foreign government agency in collaboration with a public health authority; or reporting child abuse or neglect; (b) activities related to the quality, safety or effectiveness or activities or products regulated by the Food and Drug Administration; (c) notifying a person who may have been exposed to a communicable disease or may otherwise be at risk of spreading a disease or condition.

6. **Abuse, Neglect or Domestic Violence**: ARC may disclose your PHI to a government authority authorized to receive reports of abuse, neglect or domestic violence if it reasonably believes that you are a victim of abuse, neglect or domestic violence. Any such disclosure will be made: 1) to the extent it is required by law; 2) to the extent that the disclosure is authorized by statute or regulation and ARC believes the disclosure is necessary to prevent serious harm to you or other potential victims; or 3) if you agree to the disclosure.

7. **Health Oversight Activities**: ARC may disclose your PHI to a health oversight agency for any oversight activities authorized by law, including audits; investigations; inspections; licensure or disciplinary actions; civil, criminal or administrative actions or proceedings; or other activities necessary for the oversight of the health care system, government benefit programs, compliance with government regulatory program standards or applicable laws.

8. **Judicial and Administrative Proceedings**: ARC may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process upon receipt of "satisfactory assurance" that you have received notice of the request.

9. **Law Enforcement Purposes**: ARC may disclose limited PHI about you for law enforcement purposes to a law enforcement official: (a) in compliance with a court order, a court-ordered warrant, a subpoena or summons issued by a judicial officer or an administrative request; (b) in response to a request for information for the purposes of identifying or locating a suspect, fugitive, material witness or missing person; (c) in response to a request about an individual that is suspected to be a victim of a crime, if, under limited circumstances, ARC is not able to obtain your consent; (d) if the information relates to a death ARC believes may have resulted from criminal conduct; (e) if the information constitutes evidence of criminal conduct that occurred on the premises of ARC ; or (f) in certain emergency circumstances, to alert law enforcement of the commission and nature of a crime, the location and victims of the crime and the identity, or description and location of the perpetrator of the crime.

10. **Coroners, Medical Examiners and Funeral Directors**: ARC may disclose your PHI to a coroner or medical examiner for the purpose of identification, determining a cause of death or other duties authorized by law. ARC may disclose your PHI to a funeral director, consistent with all applicable laws, in order to allow the funeral director to carry out his or her duties.

11. **Research**: ARC may use or disclose your PHI for research purposes, provided than an institutional review board authorized by law or a privacy board waives the authorization requirement and provided that the researcher makes certain representations regarding the use and protection of the PHI.

12. **Serious Threat to Health or Safety**: ARC may disclose your PHI, in a manner which is consistent with applicable laws and ethical standards, if the disclosure is necessary to prevent or lessen a serious threat to health or safety of a person or the public, or the information is necessary to apprehend an individual.

13. **Specialized Government Functions**: ARC may also disclose your PHI, (a) If you are a member of the United States or foreign Armed Forces, for activities that are deemed necessary by appropriate military command authorities to assure the proper execution of a military mission; (b) to authorized federal officials for the conduct of lawful intelligence, counter-intelligence and other national security activities authorized by law; (c) to authorized federal officials for the provision of protective services to the President, foreign heads of state, or other people authorized by law and to conduct investigations authorized by law; or (d) to a correctional institution or a law enforcement official having lawful custody of you under certain circumstances.

14. **Workers' Compensation**: ARC may disclose your PHI as authorized by, and in compliance with, laws relating to workers' compensation and other similar programs established by law.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT

15. If you do not object to the following uses or disclosures of your PHI, ARC may: 1) disclose to a family member, other relative, a close personal friend, or other person identified by you the information relevant to their involvement in your care or payment related to your care; 2) notify others, or assist in the notification, of your location, general condition, or death; or 3) disclose your PHI to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES OF PHI

16. Any use or disclosure of your PHI that is not listed herein will be made only with your written authorization. You have the right to revoke such authorization at any time, provided that the revocation is in writing, except to the extent that: 1) ARC has taken action in reliance on the prior authorization; or 2) If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

YOUR RIGHTS REGARDING YOUR PHI

17. **Restriction of Use and Disclosure**: You have the right to request that ARC restrict the PHI it uses and discloses in carrying out treatment, payment and health care operations. You also have the right to request that ARC restrict the PHI it discloses to a family member, other relative or any other person identified by you, which is relevant to such person's involvement in your treatment or payment for your treatment. By law, ARC is not obligated to agree to any restriction that you request. If ARC agrees to a restriction, however, it may only disclose your PHI in accordance with that restriction, unless the information is needed to provide emergency health care to you. If you wish to request a restriction on the use and disclosure of your PHI, please send a written request to the Privacy Officer which specifically sets forth: 1) that you are requesting a restriction on the use or the disclosure of your PHI; 2) what PHI you wish to restrict; and 3) to whom you wish the restrictions to apply (e.g., your spouse). ARC will not ask why you are requesting the restriction. The Privacy Officer will review your request and notify you whether or not ARC will agree to your requested restriction. You also have the right to request to restrict disclosure of your PHI to a health plan, if the disclosure is for payment or health care operations and the disclosure pertains to a health care item or service for which you have paid out of pocket in full.

18. **Authorization Required**: Most uses and disclosures of PHI for marketing and the sale of PHI require your authorization. In addition, disclosure of psychotherapy notes is prohibited without your authorization, except as allowed by law.

19. **Fundraising**: ARC may contact you for purposes of fundraising to support its programs. You have the option to opt-out of this type of communication.

20. **Confidential Communications**: You have the right to receive confidential communications of your PHI. You may request that you receive communications of your PHI from ARC in alternative means or at alternative locations. ARC will accommodate all reasonable requests, but certain conditions may be imposed.

To request that ARC make communications of your PHI by alternative means or at alternative locations, please send a written request to the Privacy Officer setting forth the alternative means by which you wish to receive communications or the alternative location at which you with to receive such communications. ARC will not ask why you are making such a request.

21. **Access to PHI**: You have the right to inspect and obtain a copy of your PHI maintained by ARC. Under HIPAA, you do not have the right to inspect or copy information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding, or information that ARC is otherwise prohibited by law from disclosing.

If you wish to inspect or obtain a copy of your PHI, please send a written request to the Privacy Officer. If you request a copy of your PHI, ARC may charge a fee for the cost of copying and mailing the information. You may also request that a copy of your PHI be transmitted to you electronically.

HIPAA permits ARC to deny your request to inspect or obtain a copy of your PHI for certain limited reasons. If access is denied, you may be entitled to a review of that denial. If you receive an access denial and want a review, please contact the Privacy Officer. The Privacy Officer will designate a licensed health care professional to review your request. This reviewing health care professional will not have participated in the original decision to deny your request. ARC will comply with the decision of the reviewing health care professional.

22. **Amending PHI**: You have the right to request that ARC amend your PHI. To request that an amendment be made to your PHI, please send a written request to the Privacy Officer. Your written request must provide a reason that supports the request amendment. ARC may deny your request if it does not contain a reason that supports the requested amendment. Additionally, ARC may deny your request to have your PHI amended if it determines that: 1) the information was not created by ARC and amendment may be made elsewhere; 2) the information is not part of a medical or billing record; 3) the information is not available for your inspection; or 4) the information is accurate and complete.

23. **Notification of Breach**: ARC will notify you following a breach of your PHI as required by law.

24. **Accounting of Disclosure of Your PHI**: You have the right to request a listing of certain disclosure of your PHI made by ARC during the period of up to six (6) years prior to the date on which you make your request. Any accounting you request will not include: 1) disclosures made to carry out treatment, payment or health care operations; 2) disclosures made to you; 3) disclosures made pursuant to an authorization given by you; 4) disclosures made to other people involved in your care or made for notification purposes; 5) disclosures made for national security or intelligence purposes; 6) disclosure made to correctional institutions or law enforcement officials; or 7) disclosures made prior to April 14, 2003. The right to receive an accounting is subject to certain other exceptions, restrictions and limitations set forth in applicable statutes and regulations.

To request an accounting of the disclosures of your PHI, please send a written request to the Privacy Officer. Your written request must set forth the period for which you wish to receive an accounting. ARC will provide one free accounting during each twelve (12) month period. If you request additional accountings during the same twelve (12) month period, you may be charged for all costs incurred in preparing and providing that accounting. ARC will inform you of the fee for each accounting in advance and will allow you to modify or withdraw your request in order to reduce or avoid the fee.

25. **Obtaining a Copy of this Notice**: You have the right to request and receive a paper or electronic copy of this Notice at any time.

COMPLAINTS

26. If you believe that your privacy rights have been violated, you may file a complaint with ARC or with the Secretary of Health and Human Services. To file a complaint with ARC, please contact the Privacy Officer at the address listed on page 1 of this notice. All complaints must be submitted in writing. ARC WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.