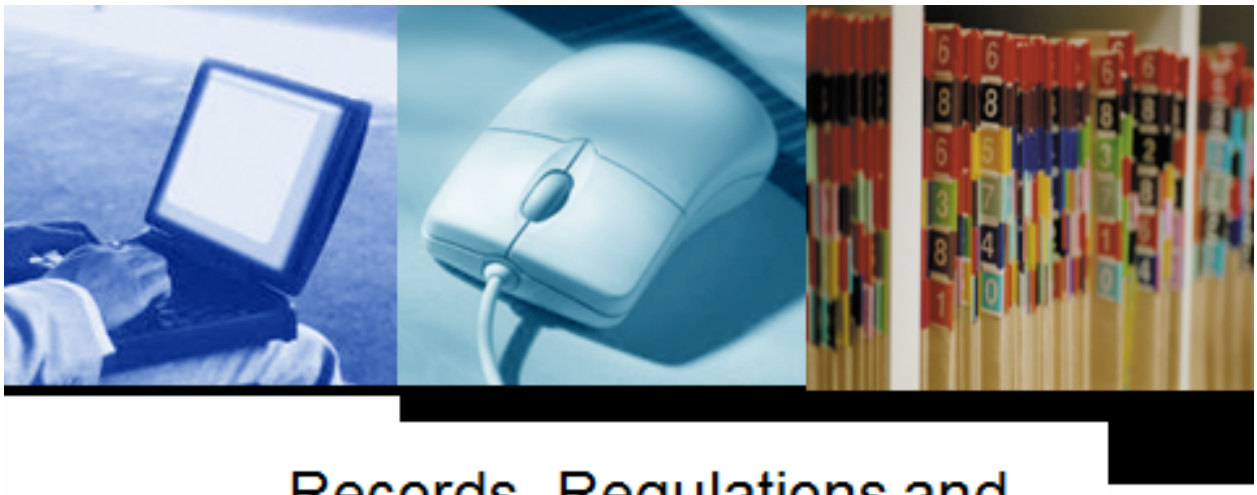


Records, Regulations and Ethics for the Entire Dental Team

Chester J. Gary, DDS, JD
Clinical Assistant Professor
UB School of Dental Medicine
2012 Buffalo Niagara Dental Meeting

gary@buffalo.edu

35th Annual Buffalo Niagara Dental Meeting

October 4, 2012

STRONG HEALTH

UNIVERSITY OF ROCHESTER
MEDICAL CENTER

PATIENT E-MAIL CONSENT FORM

Patient Name: _____

Patient MR#: _____

Patient E-mail: _____

Provider: Dr. _____

Provider E-mai _____

Personal Representative*:

Name: _____

Relationship: _____

E-Mail: _____

** see HIPAA Policy 0P16 Personal Representative*

1. RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider. These include, but are not limited to, the following:

a) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) E-mail senders can easily misaddress an E-mail.
c) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
d) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
e) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
f) E-mail can be used to introduce viruses into computer systems.

2. CONDITIONS FOR THE USE OF E-MAIL

The Provider cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. The Patient and Provider must consent to the following conditions:

a) E-mail is not appropriate for urgent or emergency situations. The Provider cannot guarantee that any particular E-mail will be read or responded to.
b) E-mail must be concise. The Patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
c) E-mail communications between patient and provider will be filed in the Patient's permanent medical record.
d) The Patient's messages may also be delegated to another provider or staff member for response. Office staff may also receive and read or respond to patient messages.
e) The Provider will not forward patient-identifiable E-mails outside of the URMC healthcare system without the Patient's prior written consent, except as authorized or required by law.
f) The Patient should not use E-mail for communication regarding sensitive medical information.
g) It is the Patient's responsibility to follow up and/or schedule an appointment if warranted.
h) Recommended uses of patient-to-provider E-mail should be limited to:
   a. Appointment requests
   b. Prescription refills
   c. Requests for information
   d. Non-urgent health care questions
   e. Updates to information or exchange of non-critical information such as laboratory values, immunizations, etc.

3. INSTRUCTIONS

To communicate by E-mail, the Patient shall:

a) Avoid use of his/her employer's computer.
b) Put the Patient's name in the body of the E-mail.
c) Put the topic (e.g., medical question, billing question) in the subject line.
d) Inform the Provider of changes in the Patient's E-mail address.
e) Take precautions to preserve the confidentiality of E-mail.
f) Contact the Provider's office via conventional communication methods (phone, fax, etc.) if the patient does not receive a reply within a reasonable period of time.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Provider and me. I consent to the conditions and instructions outlined here, as well as any other instructions that the Provider may impose to communicate with me by Email. I agree to use only the pre-designated e-mail address specified above. Any questions I may have had were answered.

_____

Patient or Personal Representative signature

Date _____

_____

Provider signature

Date _____

SH 42
(09/2005) Original – to be retained in Medical Record Copy – to be given to the Patient/Personal Representative

AMA
AMERICAN
MEDICAL
ASSOCIATION

Sunday, January 29 2012

AMA Policy: Professionalism in the Use of Social Media

The Internet has created the ability for medical students and physicians to communicate and share information quickly and to reach millions of people easily. Participating in social networking and other similar Internet opportunities can support physicians' personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, provide opportunity to widely disseminate public health messages and other health communication. Social networks, blogs, and other forms of communication online also create new challenges to the patient-physician relationship. Physicians should weigh a number of considerations when maintaining a presence online:

(a) Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.

(b) When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, content is likely there permanently. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.

(c) If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines just, as they would in any other context.

(d) To maintain appropriate professional boundaries physicians should consider separating personal and professional content online.

(e) When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.

(f) Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine public trust in the medical profession.

Disclaimer

Notice to Website Viewers:

This web site is provided for information and education purposes only. No doctor/patient relationship is established by your use of this site. No diagnosis or treatment is being provided. The information contained here should be used in consultation with a dentist of your choice. No guarantees or warranties are made regarding any of the information contained within this web site. This web site is not intended to offer specific medical, dental or surgical advice to anyone. Further, this web site and our practice take no responsibility for web sites hyper-linked to this site and such hyperlinking does not imply any relationships or endorsements of the linked sites.

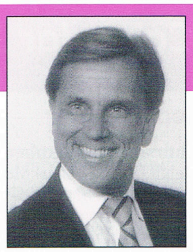
8th District
Bulletin
Volume 43, No. 3 Fall 2007

Eighth District Dental Society of the State of New York
3831 Harlem Road Buffalo, N.Y. 14215
(716) 995-6300 FAX (716) 995-6305

American Dental Association 800-621-8099
New York State Dental Association 800-255-2100

Member Publication
American Association of Dental Editors
The Bulletin of the Eighth District Dental Society (USPS 909–900) is published four times a year, in Feb., April, Aug. and Nov. by the Eighth District Dental Society for its members at a $2.00 annual subscription rate. Unless officially adopted by the Eighth District Dental Society and so indicated, opinions expressed in this publication are not necessarily the views of the association.
Address all communications pertaining to this Bulletin to the Editor, Eighth District Dental Society, 3831 Harlem Road, Buffalo, New York 14215. POSTMASTER send address changes to the Bulletin of the Eighth District Dental Society, 3831 Harlem Road, Buffalo, New York 14215. Material for publication should be submitted three weeks prior to the month of publication.

From the Editor



Ethics-Based Risk Management: Do the Right Thing

By Chester J. Gary, DDS, JD

"Keep accurate and complete records". "Obtain written informed consent". "Practice defensively". These risk management mantras constitute good legal advice. However, risk management techniques alone, without adherence to fundamental ethical values, will not successfully protect dental practices from exposure to legal action. Only an ethics-based practice supplemented with sound risk management strategies can ensure dentists will do the right thing and be able to defend it.

The American Dental Association Principles of Ethics form the aspirational goals of our profession. Along with the Code of Professional Conduct, they challenge dentists to treat others the way they want to be treated or, in effect, to do the right thing. The Code's principles form the basis of most of the laws which regulate clinical practice. For example: "Patient Autonomy" – Informed Consent; "Do No Harm" – Credentialing regulations, assault and battery, defamation; "Do Good" – Professional Negligence; "Be Fair" – Antidiscrimination, labor laws; and "Be True" – Contracts, confidentiality, fraud. These ethical values and bodies of law exist on a continuum, where the laws function as a minimum enforcement of the higher ethical values. Hence, ethical conduct stands far above the behavior mandated under law; an effective risk management guideline.

An ethics-based practice requires dentists to strive for higher values. It makes it more likely they will surpass minimum legal standards than if they merely aim for legal compliance. In so doing, the ethical guidelines assure they correctly place their primary focus on the best interests of the patient, not on protecting their own legal position. Acting in the best interests of the patient and trying to do the right thing will nurture the dentist-patient relationship and increase mutual trust. This will, in turn, form the foundation for risk management activities.

Make no mistake, ethical practice alone is not enough to ensure protection from legal exposure. Risk management strategies are necessary to make good dentistry legally defensible. They function to establish, through good communication and documentation, admissible evidence of the existing ethical values. Hence, these strategies are most effective when applied in an ethics-based environment, not as an end in and of themselves.

Risk management techniques alone, without adherence to fundamental ethical values, will not successfully protect dental practices from exposure to legal action.

At times, dentists may be tempted to compromise ethical values for what may seem, at the time, good business reasons. Increasing overhead costs, combined with third party managed fee controls, can erode dentists' resolve to invest the necessary time, effort and money in their practices and professional organizations. At some point, they lose sight of the ethical principles set forth by our profession and mistakenly believe that defensive dentistry alone will relieve them of the hard work required of an ethics-based practice.

A risk management program in the absence of ethical values allows and even encourages practitioners to "get by" with marginal compliance of standards. Under these circumstances, the program is being applied for the wrong reasons: to protect and defend the dentist rather than in the best interests of the patient. Most importantly, when dentists focus on their own defense, it alienates patients who are then treated as adversaries, not partners in treatment. It will have the reverse effect of decreasing doctor-patient trust which produces dissatisfied patients more likely to elect legal recourse.

Knowing the right thing to do in difficult situations will always present a chal-

see Editor *page 15*

Editor *from page 3*

lenge to the practitioner. It is hard work and time consuming to proactively strive for higher values. It involves constant self analysis and courage to "catch yourself" in any potential violation. It is much easier to merely react to legal threats with defensive conduct and try to "not get caught". Dentists need to refocus their efforts on the best interests of the patient and reunite risk management with underlying ethical values; not only to experience reduced exposure to legal claims, but also to enjoy the greater satisfaction of meeting the needs of those we serve. So, when faced with a clinical crisis or ethical dilemma, don't merely do the defensive thing, do the right thing!

Please address any questions or comments to Chester J. Gary, DDS, JD at garyddsjd@roadrunner.com.

2008 Eighth District
President's Reception
Saturday, January 12
6 p.m. Cocktails 7 p.m. Dinner
Brierwood Country Club, Hamburg

SAVE THE DATE

8th District
Bulletin
Volume 48, No. 1 Winter, 2012

Eighth District Dental Society
of the State of New York
3831 Harlem Road Buffalo, N.Y. 14215
(716) 995-6300 FAX (716) 995-6305

American Dental Association 800-621-8099
New York State Dental Association 800-255-2100

Member Publication
American Association of Dental Editors
The Bulletin of the Eighth District Dental Society (USPS 909-900) is published five times a year by the Eighth District Dental Society for its members at a $40.00 annual subscription rate. Unless officially adopted by the Eighth District Dental Society and so indicated, opinions expressed in this publication are not necessarily the views of the association.
Address all communications pertaining to this Bulletin to the Editor, Eighth District Dental Society, 3831 Harlem Road, Buffalo, New York 14215. POSTMASTER send address changes to the Bulletin of the Eighth District Dental Society, 3831 Harlem Road, Buffalo, New York 14215. Material for publication should be submitted three weeks prior to the month of publication.

The Dental Society is organized for the purpose of encouraging improvement of the health of the public, to promote the art and science of dentistry, and to represent the interests of the members of the profession and the public which it serves.

From the Editor

AS PROFESSIONALS, USE SOCIAL MEDIA TO PROMOTE DENTISTRY, NOT OURSELVES

By Chester J. Gary, DDS, JD

Facebook, Twitter, LinkedIn, YouTube, Private Blogs. As social media use explodes in today's society, dentists feel increased pressure to maintain an online presence. Since these powerful internet tools disseminate information to millions quickly, and with permanency, they present significant new challenges to the individual dentist's reputation, and the image and status of dentistry as a profession. How dentists and organized dentistry utilize and respond to social media will, in great part, determine whether the public will view dentistry as a profession or trade.

Key characteristics which distinguish dentistry as a profession rather than a trade include the obligations to place the best interests of patients above the dentist's self-interest, to respect patients' autonomy and privacy in the dentist-patient relationship and to value the trust between dentistry and the public above that of unrestricted trade. Three main uses of social media test dentists' adherence to these traits.

First, patients increasingly turn to internet websites to research their health related questions before they visit the dentist. The danger arises when they encounter unreliable and inaccurate information from financially biased sources. When patients demand inappropriate treatment based upon misinformation or misconceptions obtained online, dentists who maintain a commercial view of dentistry often use this as an opportunity to sell unnecessary or ill-advised treatment for the dentist's financial gain. This passive deception violates the dentist's obligation to place the best interests of the patient above self-interest. Patients treated in this manner will ultimately view dentists as opportunistic sales persons they need to guard against rather than caring professionals that guard them.

"How dentists and organized dentistry utilize and respond to social media will, in great part, determine whether the public will view dentistry as a profession or trade."

Second, social networking provides opportunities for dentists to "friend" patients on Facebook, respond to patient criticisms on practice rating sites, or post treatment-related information on blogs. Communications that directly or indirectly identify a patient violate the HIPAA privacy rule and the professional obligation to protect patient confidentiality. Since social media distributes information instantaneously to a wide audience and creates a permanent electronic record, likely discoverable in litigation, it magnifies these risks. Dentists' careless management of protected health information online will dissipate patients' trust in the dentist-patient relationship. Patients will begin to view this private and long-term relationship as more of a public commercial transaction.

Third, social media can function as the ultimate practice marketing tool. However, when dentists post negative or unethical advertising on the internet where they claim superiority over other similarly credentialed practitioners, it undermines the public trust in other dentists. Use of arguably false and misleading persuasive tactics further indicates to the public that dentists hold a commercial view of their own calling where unrestricted competition supersedes the public trust in dentistry. Patients conclude that, like other trades, they can no longer expect standardized quality among dentists.

Continued on page 6

Social Media

Continued from page 2

Dentists and organized dentistry must meet the challenges of social media to maintain our reputation as professionals. Individual dentists must respond to misinformation online, threats to patient privacy and misleading marketing in light of the obligations that define dentistry as a profession. Rather than succumb to the risks of social media, we must manage internet tools to educate patients regarding the importance of oral health in their overall health and the options dentistry offers to achieve it. In addition, organized dentistry must formulate a social media policy to guide practitioners in its appropriate use. As a profession, we can succeed if we utilize social media as an opportunity to promote dentistry, not ourselves.

Please address any questions or comments to Chester J. Gary, DDS, JD at garyddsjd@roadrunner.com.

Hidden Treasures

Continued from page 3

wonderful job promoting and protecting our profession.

This is what I mean by hidden treasures found in organized dentistry. You may not notice it every day but in the long run the intangible benefits come shining through. Once again, thank you for the opportunity to serve as your President and if you need to contact me, my office phone number is 716-297-1675 and my email is drrndowd@msn.com.

Newly Endorsed – MVP Network Consulting

MVP Network Consulting is a 24/7/365 outsourced IT company specializing in Health Care and Dental Technology solutions. Their 4 distinctive service divisions are:

1. IT Services – Helpdesk Support, Network Security, Healthcare IT certified.

2. Cloud Computing – Hybrid options that are specifically suited to each client's needs.

3. Telephony – Communication solutions for large organizations and for small companies.

4. Web and Application Development – Websites and custom applications.

For more information, contact Kevin Kirby at 716-362-7586.

The Electronic Health Record in Dentistry
Unlimited Promise, Limited Progress

The electronic health information network is moving from concept to reality. Dentists, like other healthcare professionals, need to be ready to embrace it.

Chester J. Gary, D.D.S., J.D.

CURRENT HEALTH CARE REFORM and recent federal legislation envision creation of a nationwide electronic health information network. As a key component, electronic health records (EHRs) inevitably will replace written patient records.[1] Only the EHR, which includes computer files, digital images, videos, e-mails, databases and backups, can consolidate all of a patient's health information and deliver decision and communication support at the point of care.

Despite its advantages, however, surveys indicate low levels of adoption of EHRs in hospitals,[2,3] with even lower utilization in private offices.[4] Several barriers and risks impede the conversion from paper to digital. These include poor usability and high cost to implement and maintain, the potential increase in clinical hazards and errors, and the threat of unauthorized access and use of confidential health information. The health care system, including the dental profession, owes it to the public to overcome these challenges, so that patients can enjoy the benefits of the EHR without succumbing to its risks.

The EHR, through the Internet, enables functions that paper records cannot deliver.[5] Its benefits include:

- Availability of patient health information (PHI) when and where needed.
- Consolidation of the current total PHI, including diagnostic radiographic and test images and results in one location.
- Decision support and computation of information (in addition to storage) to alert providers to clinical guidelines, drug allergies and interactions, and lab and test results.
- Creation of a patient's personal health record (PHR) linked to the EHR and patient's computer for informational web resources.
- Improved provider follow-up with secure messaging e-mail for postoperative instructions and reminders.
- Immediate order and filling of prescriptions and filing of claims.
- Identification of patients at risk.
- Detection of fraud and abuse.

If realized, these functions would provide a more comprehensive profile of a patient's health care status, decrease record fragmentation and duplication of tests and services, and increase efficiency and safety.

Barriers to Implementation

The high cost and complexity of implementation stand as the first barriers to initial users, especially in private practices. Most practitioners lack the expertise to perform the necessary due diligence to make informed decisions regarding proper selection and use in practice.[6] Although federal legislation financially incentivizes the use of EHRs for providers of Medicare and Medicaid patient services,[7] the vast majority of dentists must rely upon their own financial resources and the informational resources of organized dentistry and government agencies for support.

Secondly, until vendors, technical support staff and providers master contemporary EHR system technology, users risk actually increasing clinical hazards and errors. Product defects and software flaws can lead to fatal outcomes, such as life-threatening drug dose errors.[8] The EHR requires doctors to complete templates and allows them to cut and paste other providers' notes. This reduces time spent in patient dialogue and creative clinical thinking, which interferes with, rather than supports, the doctor-patient relationship, leading to increased user error.[9]

In addition, the system can rapidly disseminate erroneous information before it is corrected, thus, compounding potential injury. While the integration of decision-support technology, such as clinical practice guidelines, prompts and alerts should improve patient care, it could, at the same time, distract clinicians, reshape the standard of care and create negative evidence to increase provider liability when providers, for whatever reason, ignore the support.[10]

Thirdly, the digital storage and transfer of confidential health information exponentially increases the risk of unauthorized access and use associated with hacking, computer theft and malicious or accidental disclosures. Most breaches of security result from human error and carelessness. These include sharing passwords, not using passwords, failing to encrypt data and losing laptops or flash drives with identifiable health information.[11] Even mistakenly sending a file to an e-mail list server could disclose information to an international audience.[12] In 2008, hackers stole 2.1 million patient computer files with health information from the University of Miami Health System.[13]

Despite HIPAA (Health Insurance Portability and Accountability Act) Privacy and Security Rules, a 2008 report by the HHS Office of the Inspector General concluded that the federal government has failed to provide adequate oversight or effective enforcement of the HIPAA Regulations.[14] Patients themselves express deep concern over the privacy and security of electronically stored health information. One survey found that to protect the confidentiality of their health information, 13% of respondents admitted avoiding office visits and tests, and paying out of pocket to eliminate the electronic documentation they would create.[15]

Rising to the Occasion

In conclusion, organized medicine and dentistry must work with federal and state governments to legislate more stringent regulations regarding the safety and privacy of EHR systems with system guidelines and enforceable safeguards and sanctions. The information technology industry, with guidance from the health professions, must continue to aggressively develop user-friendly, interoperable systems that maximize the benefits and minimize the risks of EHR technology. Professional societies must educate and train doctors and support staff on how to select, use and maintain digital systems and supervise the drafting of clinical guidelines.[16] Only cooperation among these stakeholders can protect patient privacy and safety as health care converts to digital.

The profession of dentistry must recognize that the formation of a nationwide electronic health information network places it at a crossroads. Dentists will need to manage the oral health of an aging population with increasingly complex medical problems. The healthcare system will require a dental workforce equipped to meet this challenge. Hence, organized dentistry must ensure that dentists have the ability to share critical medical and dental information with medical practitioners utilizing stan-

dardized electronic documentation systems.[17] Dentistry must succeed in this transition not only to competently meet the needs of its patients, but also to ensure it remains an integral part of national and global health care strategies.⌘

Dr. Gary is a practicing attorney and general dentist in Western New York and clinical assistant professor at the University at Buffalo School of Dental Medicine. He serves on the NYSDA Professional Liability Insurance Council. He can be reached at garyddsjd@roadrunner.com.

REFERENCES

1. Blumenthal D. N Engl J Med 2011; 365:2426-2431.
2. Jha A, Ferris T, Donelan K, et al. How common are electronic health records in the United States? A summary of evidence. Healti. Aff (Millwood) 2006; 25.
3. DesRoches CM, Campbell EG, Rao SR, et el. Electronic health records in ambulatory care – a national survey of physicians. N Eng J Med 2008 259:50-60.
4. Lohr, S. Most Doctors Aren't Using Electronic Health Records, NY Times, June 19, 2008, citing N Eng J Med 2008 Survey, NYTimes.com., citing Jha A, DesRoche C, et al., Use of Electronic Health Records in US Hospitals. N Engl J Med 2009;360:1628-38.
5. Centers for Medicare and Medicaid Services. Electronic Health Records at a Glance. Media Release Database, July 13, 2010.
6. Supra Note 3.
7. Dept of Health and Human Services, Centers for Medicare and Medicaid Services, 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule, http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.
8. Hope Yen, BlueCross BlueShield Association, Veterans Exposed to Incorrect Drug Doses, (Jan. 13, 2009), http://www.bcbs.com/news/national/veterans-exposed-to-incorrect-drug-doses.html.
9. Hartzban P, Groopman J. Off the record – avoiding the pitfalls of going electronic, N Eng J Med 358; 16, Apr 17, 2008, p.1657.
10. Hoffman S, Podgurski A. E-Health Hazards: Provider Liability and Electronic Health Record Systems, Berkeley Tech Law Journal, p. 1548 (2009), http://btlj.org/data/articles/24_4/1523_Hoffman.pdf.
11. Supra, Note 1.
12. Hoffman S, Podgurski A. In Sickness, Health and Cyberspace: Protecting the Security of Electronic Private Health Information, 48 B.C. L. Rev. 333 (2007).
13. American Medical Association, News in Brief: Miami Patient Data Stolen, Am. Med. News, May 19, 2008, http://www.ama-assn.org/amednews/2008/05/19/bibf0519.htm.
14. Levinson D. Dept. of Health and Human Services, Nationwide Review of the Centers for Medicare and Medicaid Services Health Insurance Portability and Accountability Act of 1996 Oversight, A-04-07-05064, 3 (2008). http://www.oig.hhs.gov/oas/reports/region4/ 40705064.pdf.
15. Bishop L, et al. Cal. HealthCare Found, National Consumer Health Privacy Survey 2005 (2005).
16. American Dental Association, The ADA Standards Committee on Dental Informatics (SCDI), ADA Technical Report No. 1044: Clinical Software Performance for Dental Practice Software, www.adacatalog.org.
17. Heid DW, Chasteen J, Forrey AW. The electronic health record, J Contemp Dent Pract 2002 Feb;(3)1:43-54.

Closing a Dental Practice

A difficult decision can become nightmarish if not handled properly.

Lance R. Plunkett, J.D., LL.M.

Whether by choice or necessity, there probably will come a time when you will have to wind down the business operations of your dental practice. Whether you are selling the practice to another dentist or closing it entirely, there are many issues to address. Keep in mind, too, that your obligations as a dentist do not cease when your doors close.

As with most things in life, it is best to prepare in advance. Patients should be advised of the pending closing of the practice and given the opportunity to seek a new dentist. The law does not specify an exact time period for giving notice, and it certainly would be dependent upon many factors, but where possible, it is not advisable to wait until the last minute. The standard of reasonability should be your guide.

If there is a sale of the practice, it is not appropri-

continued on page 14

Sample Generic Letter for Closing a Practice

Dear Patient Name:
Please be advised that due to _____
(my retirement, health reasons, etc.)

I am discontinuing the practice of dentistry on ____(Date) _____,20 ____. I shall not be able to attend to you professionally after that date.

Please be advised of your need for continued care. I suggest that you arrange to place yourself under the care of another dentist. If you are not acquainted with another dentist, I suggest that you contact the _____Dental Society, telephone number (____) ____ - _____.

I shall make my records of your case available to the dentist you designate below. Since your records are confidential, I shall require your written authorization to make them available to another dentist. For this reason, I am including at the end of this letter an authorization form. Please complete the form and return it to me.

I am sorry that I cannot continue as your dentist. I extend to you my best wishes for your future health and happiness.

Very truly yours,

_____, D.D.S./D.M.D.

AUTHORIZATION TO TRANSFER RECORDS

Date: _____

To: _____, D.D.S./D.M.D.

I hereby authorize you to transfer or make available to _____, D.D.S./D.M.D., _____all the records and reports relating to my dental treatment.
(address)

Signed: _____

Chester J. Gary, DDS, JD
Clinical Assistant Professor
University at Buffalo School of Dental Medicine
gary@buffalo.edu

Chester J. Gary, DDS, JD is a Clinical Assistant Professor in the Department of Restorative Dentistry and Course Director of Practice and Risk Management, University at Buffalo School of Dental Medicine. He is a practicing general dentist, licensed in New York, and an attorney-at-law, admitted in New York and Florida. His law practice is concentrated on issues relevant to health care providers and he represents dentist employees and employers in Employment Agreements, partners in Partnership Agreements and entity formation, buyers and sellers in practice sales and dentists personally in malpractice litigation. Dr. Gary serves as a member of the New York State Dental Association (NYSDA) Attorney Panel and author and certified presenter of the New York State mandated Dental Jurisprudence and Ethics Course. He serves as Chair of the NYSDA District Professional Liability Claims Committee, Editor of the Eighth District Dental Society Bulletin and reviewing editor of the New York State Dental Journal and Journal of the American Dental Association, is a fellow of the American College of Dentists and American College of Legal Medicine, and a member of the New York and Florida Bar Associations, and Institute of Business Appraisers. Dr. Gary has published numerous articles and lectured extensively regarding dental ethics and the law.