R.A. May DDS
235 Campbell Lane
Tazewell, VA 24651
276.988.5554

HIPAA FORM

Acknowledgement of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____, understand that R.A. May, D.D.S., abides by the HIPAA Law and will protect the privacy of my personal information.

Disclosure of your information includes but is not limited to:

1. Payment- We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide you.
2. Coordination of Care- We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.
3. Lawsuits and Legal Action- We may disclose patient health information in response to a court or administrative order, a subpoena, or other lawful process.
4. Law Enforcement Purposes- We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence. It is my responsibility to inform this office of any changes in my personal or medical information. I authorize the dental team to perform any necessary dental services that I may need.

WRITTEN AUTHORIZATION TO DISCLOSE PRIVATE INFORMATION TO PERSONS OTHER THAN THE PATIENT:

I, _____, give permission to R.A. May, D.D.S.,
To discuss my patient and account information with the following:

Name _____ Relationship _____

Name _____ Relationship _____

Signature _____

Date _____