R. Alan May, D.D.S.
7051 Williamson Rd
Roanoke, VA 24019
540-366-1001

HIPAA FORM

Acknowledgement of Notice of Privacy Practices

I, _____, understand that R. Alan May, D.D.S., LLC 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. Alan May, D.D. S., LLC
To discuss my patient and account information with the following:

Name _____ Relationship _____

Name _____ Relationship _____

Signature _____

Date _____