JANE R. MAYS, DMD

GENERAL & COSMETIC DENTISTRY

NOTICE OF PRIVACY PRACTICES, ACKNOWLEGEMENDT OF RECIEPT, AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

This notice describes how health information about you may be used and disclosed. Please review it carefully. The privacy of your health information is important to us.

We use and disclose health information about you and only for treatment, payment and healthcare operations. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use or disclose your health information when we are required to do so by law. We will not use your health information for marketing communications without your written authorizations.

We may disclose your health information to a family member, friend or other person to the extent necessary to help your healthcare or with payment for your healthcare, but only if you agree that we may do so. We may disclose your health information to provide you with appointment reminders (such as voicemails messages, e-mails, postcards, phone messages at work, or letters)

I,_____ (Patient Name), direct my health and medical services, providers and payers to disclose and release my protected health and financial information to:

Name:_____ Relationship:_____

Contact Phone number:_____

I acknowledge that I have received the **NOTICE OF PRIVACY PRACTICES**.

_____ _____

(Signature of Patient or Patient's Representative) (Date)

_____ _____

(Print Name) (Date)

If written acknowledgement is not obtained, please check reason:

- ☐ Notice of Privacy Given- Patient unable to sign
- ☐ Notice of Privacy Practices Give- Patient declined to sign