Patient's Name: ___________________________

140 Piney Forest Road, Suite 3, Danville, VA 24540

THIS NOTICE DESCRIBES TO WHOM MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object we are allowed to use our professional judgment in deciding whether to discuss you medical and payment information with you family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

You may communicate with the following individuals relating to my medical or payment information:

			Type of Information Allowed to Disclose (Check one or both)		Method of Disclosure (Check one or both)	
Name	**Relationship**	**Phone Number**	**Medical**	**Billing**	**Phone**	**In Person**

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to River City Periodontics and Implants, 140 Piney Forest Road, Suite 3, Danville, Virginia, 24540. If you prefer, you can discuss your complaint in person or by phone (434-793-1400).

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office listed above.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I been offered a copy of the HIPAA Consent form.

____

Patient or Personal Representative Signature (If patient is Minor) Date