

Bruce Mayer, MD
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Notice of Privacy Practices

As a patient of Bruce M. Mayer MD, I have read and understand the Notice of Privacy Practices. I also understand that in accordance with the Notice of Privacy Practices, Dr. Mayer's office will only be able to share my medical information to the persons listed below:

Print Patient Name _____

Signature _____ Date _____

Bruce M. Mayer MD and staff have my permission to share my medical information with the following persons:

Name _____ Phone _____ Relation _____

Name _____ Phone _____ Relation _____

Name _____ Phone _____ Relation _____