Richard Goldin, DDS, Ltd.

Practice Limited to Periodontics

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(703) 821-8880

In accordance with the new Federal and State Government regulations under HIPAA (Health Insurance Portability and Accountability Act), please **initial** each item.

_____ I provide this signature as **authorization for payment** for all my dental services to Dr. Richard Goldin. I understand that partially covered services and services rejected by my insurance carrier will be solely my responsibility.

_____ I authorize Dr. Richard Goldin, as well as the office staff, to **permit the release of dental records** to other dental providers and to my insurance carrier, as needed.

_____ I authorize Dr. Richard Goldin, as well as the office staff, **to contact me to confirm appointments** at any of the telephone numbers that I have provided. They **may** ___ **- may not** ___ leave a message on an answering machine or with persons taking the message.

_____ I authorize Dr. Richard Goldin, as well as staff, **to send a postcard or a letter through the mail** as a reminder to make an appointment, or to remind me of an appointment that I have already made.

_____ I authorize Dr. Richard Goldin, as well as staff, **to telephone my selected pharmacy** with prescriptions.

_____ I authorize Dr. Richard Goldin, as well as office staff, **to contact me regarding the results of x-rays or procedures.** They **may** ___ **- may not** ___ leave a message on an answering machine or with persons taking messages at the phone numbers that I provide.

_____ I authorize the disclosure or use of my dental records when required to do so, as applicable by law.

_____ _____

Signature of patient or legal representative Date