Hal M. Hirsch, D.M.D.
Patients Acknowledgement Form HIPAA Policy

I, _____, acknowledge that I received and review the office Privacy Policy Notice for Hal M. Hirsch, D.M.D., F.A.G.D.
I authorize the release of my personal information to (list names of anyone you would want us to speak with if you aren't available about your dental treatment.)

_____

_____ I will accept communications via e-mail or text
(Initial)

email address: _____

Cell phone #: _____

_____ Messages for me can be left on my cell/home voice mail
(Initial)

Patient's Signature _____, Date _____
(Parent if patient is a minor)

If you choose not to sign this form you must give a reason why you declined to do so.

Reason for patient's refusal:

_____

Privacy Director's Signature: _____ Date: _____

Signature on File

I authorize use of my signature on all my insurance submissions.
I authorize the release of information to all my Insurance Companies.
I understand that **I am responsible for my bill**.
I authorize my doctor to act as **my** agent in helping me obtain payment from my insurance Companies.
I authorize payment directly to my doctor.
I permit a copy of this authorization to be used in place of the original.
My signature also applies to the dependents that are covered on my insurance policy.

Signature _____ Date _____