Pediatric Dentistry & Family Orthodontics

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Authorization and Consent to Send Unencrypted Patient Information by Email and Other Electronic Means

Until I request in writing to stop, I authorize Pediatric Dentistry and Family Orthodontics to transmit patient information relating to mine or my child(ren)'s treatment, health, or payment by email or other electronic means without encryption and/or special security precautions, to myself, anyone I designate, to another health care providers, to health plans and others involved in my treatment, or Pediatric Dentistry and Family Orthodontics health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I am NOT required to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will NOT be affected by either decision regarding the signing of this form.
- If I do NOT sign this form Pediatric Dentistry and Family Orthodontics' may use other means to send my information.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- Pediatric Dentistry and Family Orthodontics will not email sensitive personal information; such as Social Security numbers or Credit Card numbers in their entirety, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status.

I may notify in writing at any time to stop emailing mine or my child(ren)'s information and I am aware that this will not affect emails that Pediatric Dentistry and Family Orthodontics has already sent prior to receiving my written instructions to stop.

Patient Name (Please Print): _____

Signature: _____ Date: _____

Relationship to patient:_____