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PERMISSION TO SEND X-RAYS AND CORRESPONDENCE VIA EMAIL

I CONSENT TO THE USE OF EMAIL FOR TRANSMISSION OF MY X-RAYS AND LETTERS OF CORRESPONDENCE TO MY PERSONAL EMAIL ADDRESS AS WELL AS OTHER DENTAL OFFICES (INCLUDING REFERRALS FOR SPECIALTY CARE).

THIS FORM WILL REMAIN IN EFFECT UNTIL OTHERWISE NOTED (VIA EMAIL OR IN PERSON).

NOTE: LIKE ANY METHOD OF COMMUNICATION, THERE IS SOME RISK THAT INFORMATION SENT VIA EMAIL COULD BE READ OR ACCESSED BY A THIRD PARTY IN TRANSIT. THE PRACTICE HAS ADOPTED REASONABLE SAFEGUARDS (PASSWORD PROTECTION AND INDIVIDUAL USER IDS) TO MINIMIZE THIS RISK.

NAME OF PREVIOUS DENTIST/PRACTICE:

ADDRESS OF PREVIOUS DENTIST/PRACTICE:

TELEPHONE NUMBER OF PREVIOUS DENTIST:

EMAIL OF PREVIOUS DENTIST:

PRINT NAME:

SIGNATURE: DATE: