PATIENT ACCEPTANCE OF ELECTRONIC RISKS

Dr. Andrew J. Smith DMD and Dr. Nicholas Smith DMD

☐ I give consent that this practice may communicate my Protected Health Information (PHI) via phone call, text, or e-mail message that is not encrypted or otherwise secured. I am aware that my health information will be sent over an unsecured network and could be intercepted and used for identity theft purposes. I hereby accept those risks and absolve this practice of any liability for these e-mail transmissions.

☐ I wish to only receive encrypted forms of communication.

_____ _____

(Please Print Name) (Date)

_____ _____

(Signature of Patient Or Legal Representative) (Relationship to Patient)

FOR OFFICE USE ONLY

We attempted to obtain written acceptance of electronic risks form, but could not because:

- o Individual accepted risks verbally
- o Induvial accepted risks via electronic message
- o Other (Please specify) _____