Family Smile Center
201 West Harford St., Suite 101
Milford, Pa 18337
(570) 296-0300

Consent to Use E-mail to Exchange Personally Identifiable Information

Patient's Name:_____

E-mail Address:_____

At your request, you have chosen to communicate appointment reminders, personally identifiable information, your dental health records as well as insurance information, by e-mail without the use of encryption. Sending your personally identifiable information by e-mail has a number of risks that you should be aware of prior to giving your permission. These risks include, ***but are not limited to***, the following:

- E-mail can be forwarded and stored in electronic and paper format easily without prior knowledge of the patient
- E-mail senders can misaddress an e-mail and personally identifiable information can be sent to incorrect recipients by mistake
- E-mail sent over the Internet without encryption is NOT secure and can be intercepted by unknown third parties.
- E-mail content can be changed without the knowledge of the sender or receiver.
- Backup copies of e-mail may still exist even after the sender and receiver have deleted the messages.
- Employers and online service providers have a right to check e-mail sent through their systems.
- E-mail can contain harmful viruses and other programs.

YOU HAVE THE OPTION TO REFUSE TO COMMUNICATE WITH OUR OFFICE OR TO ALLOW OUR OFFICE TO SEND YOUR INFORMATION VIA UNENCRYPTED EMAIL. IN THE EVENT YOU WISH NOT TO SIGN THIS ACKNOWLEDGEMENT AND AGREEMENT YOU AND OUR OFFICE CAN AGREE ON AN ALTERNATIVE METHOD TO TRANSFER INFORMATION.

Patient Acknowledgement and Agreement

I acknowledge that I have read and understand the items listed above which describe some of the inherent risks of using e-mail to communicate personally identifiable information. Nevertheless, I, _____ authorize the Family Smile Center to communicate with me and on my behalf to specialists to which I have been referred by unencrypted e-mail. **I understand that the use of e-mail without encryption presents the risks noted above and may result in an unintended disclosure of such information.**

_____ ___ ____/____/____

Patient Signature (Parent or Guardian of a minor Patient) Date