ASPIRE DENTAL CARE PLLC
ADVANCED FAMILY & COSMETIC DENTISTRY
Creating Beautiful Smiles, One Patient At A Time.

Patient Consent Form for E-mail Use

Patient Name/DOB:_____

Patient address:_____

Patient e-mail address:_____

Aspire Dental Care offers patients the opportunity to communicate with our organization and providers by e-mail. Transmitting patient information by e-mail, however, has several risks that patients should consider before giving consent. These risks include, but are not limited to;

*E-mail can be circulated, intercepted, altered, forwarded, and stored in numerous paper and electronic files

*E-mail can be immediately broadcast worldwide and be received by both intended and unintended recipients.

*E-mail senders can misaddress an e-mail

*E-mails are archived, stored, and inspected through computer system adults

*E-mail can be used to introduce virus into computer systems.

*E-mail can be used as evidence in court.

CONDITIONS FOR THE USE OF E-MAIL

We will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, we cannot guarantee the security and confidentiality of e-mail communication and will not be liable for improper disclosure of confidential information that is not caused by our organization.

We will not use e-mail communication for matters that may be unlawful or contain sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, abuse, developmental disability, or substance abuse.

INSTRUCTIONS: To communicate by e-mail, we will request that a patient shall:

*Limit or avoid his/her employer's computer.

*Keep the e-amil concise, do not use for sensitive information (sexually transmitted diseases, AIDS/HIV, mental health, abuse, developmental disability, or substance abuse).

*Inform us of any changes in his/her e-mail address

*Include his/her name in the body of the e-mail

*Include specific category in the e-mail's subject line, for routing purposes (e.g., billing question)

*Review the e-mail to make sure it is clear, specific and contains relevant information before sending to our organization.

*Restricted communications from the patient must be provided if applicable

*Withdraw e-mail consent at any time by e-mail or written communication to our organization or provider.

*E-mail will not be used for urgent or emergency situations.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT FOR E-MAIL USE

I acknowledge that I have read and fully understand this e-mail consent form. I understand the risks associated with the communication of e-mail between the organization and my provider, and consent to the conditions outlined above. In addition, I agree to the instructions outlined as described, as well as any other instructions that the organization may impose to communicate with its patients by e-mail. Any questions I may have had were answered.

Patient signature:_____ **Date:**_____

Witness signature:_____ **Date:**_____

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