WESTPORT DENTAL P.C.
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: ______________________________

Westport Dental PC offers patients the opportunity to communicate with our organization and Providers by e-mail. Transmitting patient information by e-mail, however, has a number of 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 e-mail.
- E-mails are archived, stored and inspected through computer system audits.
- Email 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 maybe unlawful or contain sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, sexually transmitted diseases, and issues of abuse, developmental disability, or substance abuse.

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

- Limit or avoid use of his/her employer's computer.
- Keep the email concise, do not use for sensitive information (information regarding STD's substance abuse, mental health or HIV/AIDS)
- 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 anytime by e-mail or written communication to our organization or Provider.
- Email will not be used for urgent or emergency situations

PATIENT ACKNOWLEDGMENT AND AGREEMENT EMAIL 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