



Gilmore Dental

PATIENT ACCEPTANCE OF EMAIL RISKS

I request that this practice communicate my Protected Health Information (PHI) via an e-mail message that is not encrypted or otherwise secured, should I not be able to open the secured email. 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. We will make every attempt to send information securely, however, if unable to open we can send them not encrypted. Please sign only if you are authorizing us to send emails not encrypted.

Signature

Date

Printed Name