AUTHORIZATION AND CONSENT TO SEND UNENCRYPTED PATIENT INFORMATION BY EMAIL AND OTHER ELECTRONIC MEANS

Until I tell you in writing to stop, I authorize Russell J. Tibbetts, D.D.S., P.A. to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Dr. Tibbetts' health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

> I do not have to sign this form.
>
> My treatment, payment enrollment and eligibility for benefits will not be affect by my decision about signing this form.
>
> If I don't sign this form, our office may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
>
> There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipient. If this happens, the information may be re-disclosed and no longer protected by law.
>
> Our office does not email such sensitive personal information as social security numbers, credit card numbers, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insist.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that our office already sent before receiving my written instructions to stop.

Patient Name (please print): ____

Signature: ____ Date: ____________