"A Smile Is A Valuable Resource"

Schutze Family Dentistry

Authorization and Consent to Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Schutze Family Dentistry P.C. 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 Schutze Family Dentistry P.C.'s 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 affected by my decision about signing this form.
- If I don't sign this form, Schutze Family Dentistry P.C. 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 recipients. If that happens, the information may be re-disclosed and no longer protected by privacy law.
- Schutze Family Dentistry P.C. 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 insists.

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 Schutze Family Dentistry P.C. already sent before receiving my written instructions to stop.

______________________	______________________	______________________
Patient Signature	Patient Signature	Date

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

______________________	______________________	______________________
Representative Signature	Representative Printed Name	Date

______________________	______________________
Relationship to Patient	Source of Authority

H. John Schutze, D.D.S. • Jonathan M. Schutze, D.M.D.

Evergreen Professional Park • 453 Dixon Road, Suite 3 • Queensbury, New York 12804

(518) 793-3553 • Fax (518) 793-5695 • hjohndoc@aol.com