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Authorization and Consent
To Send Unencrypted Patient information by Email and other Electronic Means

Until I tell you in writing to stop, I authorize transmission of 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 Gail C. Thornton's, D.D.S.'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, Gail C. Thornton, D.D.S. 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.

Gail C. Thornton, D.D.S. does not email such sensitive personal information such as Social Security number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless a 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 Gail C. Thornton, D.D.S. already sent before receiving my written instructions to stop.

Patient Name (please print):_____ D.O.B. _____

Signature of patient (or guardian, if applicable) :_____

If Guardian, printed name of signee:_____

Date signed:_____