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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 Westfield Pediatric Dental Group 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 Westfield Pediatric Dental Group 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, Westfield Pediatric Dental Group 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 redisclosed and no longer protected by privacy law.
- Westfield Pediatric Dental Group does not email such sensitive personal information as Social Security number, credit card number, 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 Westfield Pediatric Dental Group already sent before receiving my written instructions to stop.

Patient name (please print) _____

Signature: _____

Date: _____

Dental Team: Give a copy of this signed form to the patient. The original copy will be scanned into the patient's chart.

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