Upstate Orthodontics, Inc., Mark L. McInnis, DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

_____
Please print patient name

Fax and E-mail Privacy Waiver

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur, I absolve this practice of all liability.

I give my consent to fax my records for the purpose of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing.

If I choose to e-mail my healthcare provider(s), I understand that e-mail is considered a convenience and is not appropriate for emergencies, or time-sensitive issues. I also understand that highly sensitive or personal information should not be communicated via e-mail.

I understand that although safeguards will be made to protect the confidentiality of any information contained within e-mail, no one can guarantee the absolute privacy of e-mail messages and that depending on their job function, staff may have the right to access any e-mail sent or received by my healthcare provider(s).

I therefore give my consent to include any e-mail pertinent to the treatment, payment, or healthcare operations in my medical records. Finally, I understand that I may withdraw this consent at any time in writing.

_____ _____

Signature of Patient/Personal Representative | Printed Name of Patient/Personal Representative

- ❑ Individual refused to sign

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).