Request for Non-Secure Communication

PATIENT

Name (Last, First Middle)

Date of Birth

Record Number

REQUEST

I understand that the GSDM Dental Treatment Centers has a secure (encrypted) e-mail alternative. Despite that, I request that the GSDM Dental Treatment Centers use non-secure (unencrypted) email and/or text to communicate with me on the following:

Communications regarding my appointments

For any communication about my health and health care

Other:

Please use the above email address for me

Please use the above number for texts

I understand that non-secure e-mail may be intercepted by persons other than the sender and recipient.

I accept all liability for any consequence of using this non-secure e mail option.

I release the GSDM Dental Treatment Centers and Boston University from any liability for using non-secure e-mail at my direction.

Once accepted by the GSDM Dental Treatment Centers, this instruction will remain in effect until I notify the GSDM Dental Treatment Centers in writing or by e mail that I revoke this instruction.

Signature of individual or representative

(if representative, relation to patient)

Date

ADMINISTRATIVE USE ONLY

Request Accepted

Request Denied because:

Signature

Title

Date

OFFICIAL USE ONLY

Individual Patient

Individual's Medical Record