

## **Agreement to Receive Electronic Communication**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I agree that the dental practice may communicate with me electronically at the email address below.

**I am aware that there is some level of risk that third parties might be able to read unencrypted emails.**

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling:

\_\_\_\_\_ 510-523-7600 or 510-865-6625 \_\_\_\_\_ **[practice's telephone number]**.

Email Address (PLEASE PRINT CLEARLY):

\_\_\_\_\_ @ \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_