Authorization and Consent
To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Gary L. Sandler DDS & Bonnie E Lipow DDS 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 Gary L. Sandler DDS & Bonnie E Lipow DDS 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, Gary L. Sandler DDS & Bonnie E Lipow DDS 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.
- The office of Gary L. Sandler DDS & Bonnie E Lipow DDS 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 authorize the office of Gary L. Sandler, DDS and Bonnie E. Lipow, DDS to send a copy of my medical records and radiographs to:

Office Name: _____

Office Address: _____

Office Telephone Number: _____ Office Fax Number: _____

Office e-mail address: _____

Patient's
Name_____

Patient's Address_____

Patient's Telephone Number_____

Patient's E-mail address:_____

A copy of this authorization is as valid as the original. This authorization will remain in effect until I revoke this authorization in writing.

Signature: _____

For: (if minor) _____ **Date:**

_____
Signature of Parent or guardian if minor

Gary L. Sandler, DDS and Bonnie E. Lipow, DDS
201 Moreland Road, Suite #8
Hauppauge, New York 11788
631-499-1800