

E-MAIL CONSENT FORM

We are asking your permission to communicate with you by e-mail in addition to written and oral communications. This saves paper, trees, our environment; makes communication instantaneous; helps you to keep organized by keeping track of information on your computer or cell phone; is the preferred method of receiving messages for many.

Patient's Name _____

Patient's Address _____

Patient's Home Telephone Number _____ Cell Phone Number _____

Patient's E-mail Address _____

I authorize the office of Gary L. Sandler, DDS and Bonnie E. Lipow, DDS to communicate with me by e-mail for the following reasons:

- Confirm Appointments
- Confirm Appointments for my following minor children _____
- Notify me of routine check-up needed
- Notify me of routine check-up needed for my following minor children _____
- Send me Newsletters
- Send me Special Offers, Bulletins and other documents

I understand that the office of Drs. Sandler and Lipow will not share by e-mail address with any other persons or agencies. No personal or confidential information will ever be transmitted. This authorization will remain in effect until I revoke this authorization in writing.

Signature

Date

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