Consent for Electronic Communication

Patient Name _____ Date of Birth_____

Parent or Guardian (if applicable) _____

I agree that Shull Family Dentistry may communicate with me using the following electronic methods:

☐ Text (Cell number) _____

☐ Email (Please Print) _____

By signing below, I agree to the following:

- I am aware that there is some level of risk that third parties might be able to read unencrypted emails and/or text messages.
- I am responsible for providing the dental practice any updates to my email and/or cell phone number
- I understand that Shull Family Dentistry will **not** sell or disclose any HIPAA protected personal contact information to any third party for marketing purpose without my expressed written permission.
- I can withdraw my consent to electronic communications at any time by calling **(503) 362-5019**

Patient Signature: _____

Date: _____

***NOTE: This service is for appointment reminders only and cannot be used for emergency contact**.