

Moore Family Dentistry

This form allows our dental practice to receive and deliver communications via email concerning your health information.

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:

843 795-4255 _____ [practice's telephone number].

Email Address (PLEASE PRINT CLEARLY):

_____ @ _____

Patient Signature: _____

Date: _____

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