

## 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: **(404) 885-1441**

Email Address (PLEASE PRINT CLEARLY):

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

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

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