Chart #: _____
FOR OFFICE USE ONLY

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

E-Mail Address: _____ Family Status: _____

Consent for Internet Communications

I grant my permission to Pallavi Sinha, D.M.D. to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured web site for Pallavi Sinha, D.M.D. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand Pallavi Sinha, D.M.D. and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that Pallavi Sinha, D.M.D. is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Pallavi Sinha, D.M.D. is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the Pallavi Sinha, D.M.D. web site with my ID and password. I also agree to immediately notify Pallavi SInha, D.M.D.of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Pallavi Sinha, D.M.D. will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Pallavi Sinha, D.M.D. has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Pallavi Sinha, D.M.D., will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand Pallavi Sinha, D.M.D. CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for Pallavi Sinha, D.M.D., and grant Pallavi Sinha, D.M.D.permission to securely upload my patient information to the web site.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian