

**Dr. Louis M. Steinberg
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Authorization and Consent

To Send Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Louis M. Steinberg, D.D.S., to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans, and others involved in my treatment, payment for my treatment, or Dr. Steinberg's health care operations. The patient information that may be emailed may include my x-rays, pictures, health history, diagnosis, treatment and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I do not sign this form Dr. Steinberg may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties and myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. IF that happens, the information may be re-disclosed and no longer protected by privacy law.
- Dr. Steinberg does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/drug abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Dr. Steinberg already sent before receiving my written instructions to stop.

Patient Name (Please Print): _____

Signature: _____ Date: _____

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