New Hampshire Center *for* Comprehensive Dentistry

New Hampshire Center for Comprehensive Dentistry (AZ Dental)

Patient Electronic Encryption Waiver

REQUEST FOR NON-SECURE COMMUNICATION

REQUEST FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, _____ AUTHORIZE: _____

(name of client) (name of clinician)

_____

(street address)

_____

TO COMMUNICATE WITH ME THROUGH NON-SECURE MEDIA PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement to receive treatment. I also understand that I may terminate this authorization at any time.

I understand that this practice makes available to me the following means of communication that are designed to be secure and to maintain confidentiality, and I still choose to request and authorize the above-named non-secure means:

- *Encrypted Electronic Communication*
- *Secure Storage Space for All Data*
- *Trained Staff*
- *Business Associate Agreement*
- *Secure Disposal*

_____ _____

(Signature of client) Date