HIPPA Consent:

Timothy Ference D.D.S.
7215 Sawmill Road Suite 110
Dublin, Ohio 43016
614-764-9755
timferencedds@gmail.com
timothyferencedds.com

HIPAA Acknowledgment:

- **I understand that I may inspect or copy the protected health information described by this authorization.**
- **I understand that at any time, this authorization may be revoked, by written revocation at the time this office receives such revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance of the authorization I have signed.**
- **I understand that my healthcare and the payment for my healthcare will not be affected If I refuse to sign this form.**
- **I understand that information used or disclosed, pursuant to authorization, could be subject to re-disclosure by the recipient, and if so, may be subject to federal or state law protecting its confidentiality.**

Signed _____ Date _____

Electronic Communication Consent

Consent for Internet Communication

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured website for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice 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 the dental practice 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 dental practice website with my ID and password. I also agree to immediately notify the dental office of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that 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 and warrant that the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with the laws directly and indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information and use their best efforts to cause all person and entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information In connection with the operations of such services and is acting on my behalf in uploading patient information. I understand the dental office will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION AND OR OTHER INFORMATIONS TRANSMITTED, MONITORED, STORED, OR UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

Signed _____ Date_____