

**Patient Communication Consent Form**

**I agree that Stieg & Wachtel Orthodontics may communicate with me using the following electronic methods.**

**Text: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

By Signing below I agree to the following:

* I can withdraw my consent to electronic communications at any time by calling 480-947-0321 and I understand that if I do withdraw my consent I will no longer receive appointment reminders.
* I understand that Stieg & Wachtel Orthodontics will not sell or disclose any HIPAA protected personal information to any third party for marketing purposes.
* I am aware that there is some level of risk that third parties might be able to read encrypted emails.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient name (printed)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature (parent if patient is a minor)**  **Date**