

Agreement to Receive Electronic Communication via Email from the office of Richard Hikade, D.D.S.

Patient Name: _____ Date of Birth: _____

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling 503-558-9828.

Email Address (PLEASE PRINT CLEARLY):

_____ @ _____

Patient Signature: _____

Date: _____