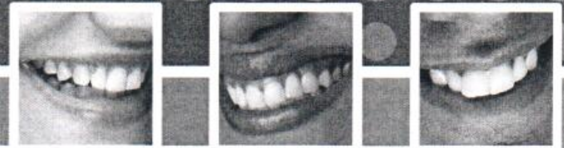
Ruland Family Dentistry
1616 Forest Drive, Suite 6
Annapolis, MD 21403-1019

(410)268-5800



Consent for Internet Communications

Patient Name:	Last	First	MI	Preferred Name

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to a secured computer server for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use by the dental practice. I also understand the dental practice is responsible for maintaining the strict confidentiality of any ID and password.

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 the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or 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 persons or 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 operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to a secured server on my behalf.

☐ I have read the information above regarding the secured uploading of patient information to the server for the dental practice, and grant the dental practice permission to securely upload my patient information to a secured server.

Signature of patient, parent, or guardian:

Signature: ______________________ Date:

Relationship to Patient:

Response Date: