



**HIPAA CONSENT AND AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATIONS**

Date \_\_\_\_\_

I, \_\_\_\_\_, **have been presented this office’s Notice of Privacy Practices.**

I, \_\_\_\_\_, agree that Aspenwood Dental Associates & Colorado Dental Implant Center 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 understand that I can withdraw my consent to electronic communications at any time. I understand that my request must be in writing and submitted via the contact information provided below.

Email Address (PLEASE PRINT CLEARLY):

\_\_\_\_\_ @ \_\_\_\_\_

Patient Signature: \_\_\_\_\_

**List of people whom we can communicate about your health information:**

\_\_\_\_\_

Submit change request to:

Aspenwood Dental Associates & Colorado Dental Implant Center  
2900 S. Peoria St., Unit C  
Aurora, CO 80014  
Attention: Cindy Schwartzkopf