Authorization and Consent
To Send Unencrypted Patient Information by Email and Other Electronic Means

Patient's Name (please print) _____

I authorize Joan M. Kanter DDS, PA to transmit patient information relating to my child's treatment, health, or payment, by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my child's treatment, payment for my child's treatment, or Joan M. Kanter DDS, PA's health care operations. The information may include x-rays, health history, diagnosis, treatment, and payment records.

There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.

_____ _____ _____

Parent/guardian's name (print) Signature Date

Photographic Release

I give permission to Joan Kanter DDS PA to take still or motion clinical photographs before, during and after procedures with the understanding that such photographs remain the property of the doctor and the practice. I authorize the doctor and her associates or designees to utilize such photographs, slides or videos and information as deemed appropriate by the practice for medical or lay groups or individuals, and/or for use on electronic digital networks or websites for publication, advertising, or demonstration. I understand that my child will not be identified by name and shall not receive compensation for the use of these images, but that it is possible she/he could be recognized from the case history or images.

_____ _____ _____

Parent/guardian's name (print) Signature Date