Laura N. Antar, MD, PhD, PLLC

Consent for Sending Medical and Billing Records Electronically

For the security of our patient's privacy, our office does not provide electronic transfer of information, as this information may contain billing and diagnosis codes or other personal and confidential information. Such information could be damaging or embarrassing were it to be misdirected or stolen. However, we understand that for convenience, some patients wish to receive some of their information by email. Any patient that wishes to receive medical and/or billing information via email or text, please read, check off and sign below to release this office of responsibility for those records potentially being viewed or used by unintended parties. Once the information leaves this office, it is no longer under our control.

☐ I understand that by checking this box and signing this form I am agreeing to have my medical information sent electronically from Laura N. Antar MD, PhD, PLLC. I understand that any information sent electronically runs the risk of a data breach. By signing this form, I understand that if a data breach or mis-direction occurs, Laura N. Antar MD, PhD, PLLC will not be held responsible.

☐ I understand that by checking this box and signing this form I am agreeing to have my billing information sent electronically from Laura N. Antar MD, PhD, PLLC. I understand that any information sent electronically runs the risk of a data breach. By signing this form, I understand that if a data breach or mis-direction occurs, Laura N. Antar MD, PhD, PLLC will not be held responsible.

Printed Name: _____ Date: _____

Patient Signature: _____.