Laura Y. Ki, D.D.S., PC
4001 Fair Ridge Drive, Suite 205, Fairfax, VA 22033
Phone: 703-273-2545 Fax: 703-273-1116

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

E-mail Address:_____ Family Status:_____

Consent for Internet Communications

I grant my permission to Laura Y. Ki, DDS to upload and store confidential patient information- including account information, appointment information and clinical information- to the secured web site for Laura Y. Ki, DDS. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand Laura Y. Ki, DDS and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that Laura Y. Ki is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Laura Y. Ki, DDS is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the Laura Y. Ki, DDS web site with my ID and Password. I also agree to immediately notify Laura Y. Ki, DDS of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand 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 Laura Y. Ki, DDS 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 patient 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 Laura Y. Ki, DDS ahs the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Laura Y. Ki, DDS will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand Laura Y. Ki, DDS CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above the secured uploading of patient information to the web site for Laura Y. Ki, DDS and grant Laura Y. Ki, DDS permission to securely upload my patient information to the web site.

_____ Date: _____ Relationship to Patient:_____
Signature of patient, parent or guardian