



DR. PAUL J. TIERNAN
 O R A L
 A N D
 M A X I L L O F A C I A L
 S U R G E R Y

30 DOCTORS PARK DRIVE
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 707-546-4727

DIPLOMATE OF THE
 AMERICAN BOARD OF ORAL
 AND MAXILLOFACIAL SURGERY

FELLOW OF THE AMERICAN
 ASSOCIATION OF ORAL AND
 MAXILLOFACIAL SURGERY

HIPAA PRIVACY OPTIONS

Patient Name _____ Date of Birth _____

Agreement to Receive Electronic Communication

I agree that Dr. Paul Tiernan's dental practice 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 can withdraw my consent to electronic communications by calling **707-546-4727**.

Email address (PLEASE PRINT CLEARLY) _____ @ _____

Release of Records

I give the office of Dr. Tiernan permission to contact my dentist or PCP as necessary for my treatment and to share my treatment records in regards to ongoing treatment. This release is valid for a period of two years from the date of signature.

Signed _____ Date _____

Permission to Share Information with persons other than dentist/physician:

I give the office of Dr. Paul Tiernan to share information regarding my appointments, treatment and financial responsibilities with the following people:

Signed _____ Date _____

I may withdraw my consent to any of the above at any time by calling 707-546-4727.