HIPAA
Privacy Agreement

ORAL SURGEONS of SANTA ROSA

Patient Name: _____

Date of Birth: _____

Agreement to Receive Electronic Communication

I agree that the providers and staff of Oral Surgeons of Santa Rosa may communicate with me electronically at the email address provided on my registration form. I am aware that there is an incalculable level of risk that third parties might be able to read encrypted or unencrypted emails. I am responsible for providing the dental practice any updates to my email address. I am aware that I can withdraw my consent at any time by writing to the practice or visiting the office to withdraw my consent.

Release of Records

I give the office of Oral Surgeons of Santa Rosa permission to contact my dentist or medical physician as necessary for my treatment and to share my treatment records, photographs, and/or digital images relative to my ongoing treatment. This release is valid for a period of five years from the date of signature.

Permission to Share Information with Persons (non-Health Care Providers)

I give the office of Oral Surgeons of Santa Rosa permission to share information regarding my appointments, treatment, and financial responsibilities with the following people:

Name	Phone	Relation

_____ _____

Signature Date