PATIENT CONSENT AND AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Address: _____

City, State, Zip: _____

I, _____, hereby authorize the release, use or disclosure of my health information as follows:

- ◯ Dental X-rays
- ◯ Other (please be specific)

  _____

Unless I request in writing otherwise, I understand that this authorization will expire on

_____ (Date). If I do not specify and expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization. You can also revoke this authorization at any time by providing written notification to: Paul Guidi, D.M.D., 1438 Court Street, Clearwater, FL 33756.

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits, however, we will be unable to fulfill your request to release your records.

_____ _____

Signature of Patient or Personal Representative Date Signed

_____

Relationship to Patient

Printed Name, Address, and Email: (Where to send the records request):

Paul Guidi, D.M.D.
1438 Court Street, Clearwater, FL 33756
7274473144 Fax: 727-446-3844
Email: info@guididental.com