



ALTSCHULER
PERIODONTIC and IMPLANT
CENTER

Consent for Release of Medical Records and Use and Disclosure of Protected Health Information

I hereby authorize the Altschuler Periodontic and Implant Center to use and disclose my entire medical record in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original.

I specifically authorize the use and disclosure of the following types of super-confidential information as stated in the NOPP – initial where appropriate below.

- _____ HIV records – including HIV test results – and sexually transmitted diseases
- _____ Alcohol and substance abuse diagnosis and treatment records
- _____ Psychotherapy records

Additionally, I authorize the disclosure of my health information to the following persons:

By Patient

Print Name _____ Date _____

Signature _____

By Patient's Guardian

Patient Name _____

Print Guardian Name _____ Date _____

Guardian Signature _____

Relationship to Patient _____

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