ALDO CICCOTELLI, M.D., P.C.

HIPAA FORM

Permission to Verbally Discuss Protected Health Information

Note: Completion of this form is optional. To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient Name: _____ Date of Birth: _____

I give my permission to Aldo Ciccotelli, M.D., P.C. to VERBALLY discuss the following medical and billing information about me (check all boxed that apply):

□ Scheduling/appointment information
□ Medical information, including my symptoms, diagnosis, medications, and treatment. *This may also include information about sexually transmitted disease (STD) testing and treatment. HIV/AIDs testing and treatment, pregnancy testing, etc.*
□ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan
□ Chemical dependency information, including my symptoms, diagnosis, medications, and treatment plan
□ Lab/radiology/test results
□ Billing and payment information
□ Other: _____

Aldo Ciccotelli, M.D., P.C. has my permission to discuss the above information with:

NAME	PHONE	RELATIONSHIP TO PATIENT

I understand that I may cancel this permission at any time by writing to Aldo Ciccotelli, M.D., P.C., but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider to share my information with someone.

This authorization expires:

□ When I cancel it in writing □ _____ (specify date)

If no expiration date is specified, this authorization will remain in effect until Aldo Ciccotelli, M.D., P.C. receives written notice to cancel it.

□ I decline to verbally discuss medical information.

_____ _____ _____
Signature of patient/guardian Date Relationship to patient

_____ _____ _____
Witness if patient is unable to sign Date Reason patient is unable to sign

***If authorized representative, please sign and attach copies of supporting documentation.