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

MEDICAL RECORDS RELEASE FORM

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

RECORDS RELEASED FROM:

DOCTOR NAME:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

PHONE:_____

SEND RECORDS TO:

ALDO CICCOTELLI, M.D., PC
106 CORPORATE DRIVE EAST
LANGHORNE, PA 19047
215-504-5253 (P) 215-504-9037 (F)

The information you may release subject to this signed release form is as follows:

☐ Complete Records

☐ Lab/Pathology Reports

☐ Hospital Reports

☐ History & Physical

☐ Medication Record

☐ Immunization Records

☐ Progress Notes

☐ Radiology Reports

☐ Operative Reports

☐ Other (please specify)

I, _____, authorize the release of medical records including those containing mental health, substance abuse, and HIV/AIDS information.

I do not have to sign this authorization to receive treatment and I have the right to refuse to sign this authorization. When my information is used pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

_____

SIGNATUE OF PATIENT OR LEGAL GUARDIAN

_____

PATIENT DATE OF BIRTH

_____

DATE