Rocco Ciccone, M.S., D.D.S.

792 S. Lapeer Rd.

Lake Orion, MI 48362

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Section A

Patient Name: ____

Address: ____

____

Phone: ____

D.O.B.: ______________ **Last 4 of SS#:**________________

Email: ____

Section B

Acknowledgement of Receipt of Privacy Practice Notice

I, ______________________ acknowledge that I have received a notice of Privacy practices from above name practice.

Signature: __________________________ **Date:** ___________________

If personal representation signs this authorization on behalf of individual, complete following:

Personal Representative's Name: _________________________________

Relationship to Patient: ____

AUTHORIZATION TO DISCLOSE PERSONAL PRIVATE INFORMATION

I, ______________________________ authorize Dr. Rocco Ciccone's office to disclose or release personal private information to individual's listed below.

NAME: ________________________ **RELATION TO PATIENT**___________