

**JOSEPH L. BACOTTI, M.D., P.C.**  
**JOSEPH L. BACOTTI, M.D., F.A.C.S.**

330 Old Country Road  
Suite 100  
Mineola, New York 11501-4145  
Telephone 516 739-6600  
FAX 516 739-6620

**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

I hereby give consent for JOSEPH L. BACOTTI, M.D., P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (JOSEPH L. BACOTTI, M.D., P.C.'s. Notice of privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. JOSEPH L. BACOTTI, M.D., P.C, reserves the right to revise its Notice of Privacy at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to JOSEPH L. BACOTTI, M.D., P. C. Privacy Officer at 330 Old Country Road, Mineola, New York 11501.

With consent, JOSEPH L. BACOTTI, M.D., P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, JOSEPH L. BACOTTI, M.D., P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, JOSEPH L. BACOTTI, M.D., P.C. may E-mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder card and patient statements. I have the right to request that JOSEPH L. BACOTTI, M.D., P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does, it is bound by this agreement.

By using this form I am consenting to JOSEPH L. BACOTTI, M.D., P.C.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, or later revoke it, JOSEPH L. BACOTTI, M.D., P. C. may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Guardian

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PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED  
HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I \_\_\_\_\_ authorize  
Patient Name

JOSEPH L. BACOTTI, M.D., P.C. to use and/or disclosure certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits JOSEPH L. BACOTTI, M.D., P.C. to use or disclosure to

\_\_\_\_\_  
Person or Entity to receive the information                      Relationship to patient

Any information that will assist the practice in carrying out TPO.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that JOSEPH L. BACOTTI, M.D., P.C. has acted in reliance upon this authorization. My written revocation must be submitted to JOSEPH L. BACOTTI, M.D., P.C. Privacy officer at 330 Old Country Road, Mineola, N.Y. 11501

\_\_\_\_\_  
Signature of patient or Guardian    Date

\_\_\_\_\_  
Print Name of Patient or Guardian