Dale John Giolas MD

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ______________________________

Previous Name: ______________________________ Social Security #: ____________________________

I request and authorize ____ to release health care information of the patient named above to:

Name: ____

Address: ____

City: ________________________________ State: __________ ZIP Code: _______________

This request and authorization applies to:

☐ Health care information relating to the following treatment, condition, or dates:

____

☐ All health care information

☐ Other: ____

Definition: Drug Screening can include urine, blood, hair, saliva and breathalyzer

☐ Yes ☐ No Drug Screening results, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ____________________________________ Date Signed: _______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.