AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, ____, hereby authorize and request
(patient, parent, or legal guardian's name)

Dr. Jack Giangiulio, D.C. and whomever he may designate as assistants to release the following information concerning my: [ ] Accident [ ] Injury [ ] Other ______________________________________

Information to be released: Patient Name: ____

[ ]	Diagnoses Only	[ ]	Reports Only	[ ]	X-rays
[ ]	Treatment Records	[ ]	Billing Records	[ ]	Copy of File

For the purpose of: ____

Release to either myself or to the below person via office pick-up or mail delivery:
(*I understand that in order to protect patient information Dr. Jack Giangiulio, D.C. does not electronically transfer patient information.)

Name: ____

Address: ____

____

____

____

*Signed: ____ Date: ___________________

[ ] patient [ ] parent [ ] legal guardian