

Offices of Dr. Jack R. Giangiulio, DC

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

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

person/organization: _____ to release

my below health care information to **Jack R. Giangiulio, D.C.** and whomever he may designate as assistants.



Information to be released:

Patient Name: _____

Diagnoses Only

Reports Only

X-rays

Treatment Records

Billing Records

Copy of File

For the purpose of: _____



If releasing by mail, send to:

Jack R. Giangiulio, D.C.
Offices of Dr. Jack R. Giangiulio, D.C.
4533 MacArthur Blvd., #546
Newport Beach, CA 92660

If releasing via facsimile, send to: (949) 851 – 2281

*Signed: _____

Date: _____

patient parent legal guardian