MARIO G. GIORGIANNI, M.D.
Physical Medicine & Rehabilitation
360 Dardanelli Lane, Suite 2-C
Los Gatos, CA 95032
Telephone: (408) 866-8604
Fax: (408) 866-5055

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FOR TREATMENT

TO:

_____
_____
_____
_____

I, _____, hereby authorize all present or former providers of medical and other health care services to furnish medical information concerning:

NAME _____
ADDRESS _____
DOB _____
PHONE _____ to be given to:

Mario Giorgianni, M.D.
360 Dardanelli Lane, Suite 2-C
Los Gatos, CA 95032
P-408-866-8604
F- 408-866-5055

Any and all information may be released including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, any drug and/or alcohol abuse records, and/or HIV test results, if any unless otherwise indicated.

_____
_____
_____
This information is for Dr. Giorgianni's use in providing treatment to the patient named above.

This authorization will remain in effect until revoked or until _____ (date).
I understand that I may receive a copy of this authorization upon request.

I agree to pay customary copying charges imposed by the provider furnishing the health records when applicable.

_____ _____
Patient or authorized person signature Date

_____ _____
Print Name of person signing, if not patient Social Security Number
If not signed by the patient, please indicate relationship.
___ Parent or guardian of minor patient
___ Guardian or conservator of patient

_____ _____
Mario Giorgianni, M.D. * Date

* The physician's signature is required for release of mental health information under the LPS Act.