



ANTHONY G. GIATRAS, M.D.

**Authorization for release of information, medical records,
notification of appointments and test results.**

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, to my parents _____
spouse _____ or medical facility. _____

Date _____ Person providing authorization _____

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities.

Date _____ Person providing authorization _____

I hereby authorize Dr. Giatras or his staff members to contact me regarding appointment reminders and leave a message on an answering machine or with a family member if I am not present or available at the time.

Date _____ Person providing authorization _____

I hereby authorize Dr. Giatras or his staff members to contact me regarding test results by leaving a message for me to return a call to the office if I am not present or available at the time of the call, or to notify me by mail.

Date _____ Person providing authorization _____

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Person providing authorization _____

Relationship to patient if not patient _____

Reason patient is unable to sign _____