**Dr. Alina Galliano-Pardo M.D.**

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**AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

**I hereby authorize Dr. Alina Galliano-Pardo, M.D. to:**

(Check all that apply):

\_\_\_\_\_ Exchange \_\_\_\_\_ obtain and/or \_\_\_\_\_ release all information pertaining to the medical, psychiatric, psychological, and/or educational evaluation and treatment of:

Patient Name (printed) Patient Date of Birth

Documents to release/request:

🞎 All medical records

🞎 Progress notes

🞎 Labs

🞎 Medications

🞎 Evaluations

|  |  |  |  |
| --- | --- | --- | --- |
| Name of person releasing/obtaining information to/from |  |  |  |
| Address |  |  |  |
| City/State/Zip |  |  |  |
| Phone Number | |  |  |
| Fax Number |  |  |  |

**A revocation may be signed at any time.**

I hereby release Dr. Alina Galliano-Pardo, M.D., from any legal liability which may arise as a result of the use of the released information.

This information has been disclosed to you from confidential records. Any further disclosure is strictly prohibited unless the client provides written consent.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of Patient (or legal guardian) |  |  |  |
| Today’s date |  |  |  |
| Signature of Witness |  |  |  |
| Today's date | |  |  |