



Kenneth A. Giraldo, M.D., P.A.

CONSENT FOR 3RD PARTY RELEASE

AUTHORIZATION FOR FAMILY, FRIENDS, OR ADVISORS TO RECEIVE INFORMATION ABOUT YOUR MEDICAL CONDITION OR THE STATUS OF YOUR BILL.

I, _____, authorize the following individual(s)
(print name)

to receive written and/or oral communications about my medical condition, care, appointments and the status of my bill. I understand that they will need to be able to provide the last four (4) digits of my social security number for verbal communication. If they should come to pick up a prescription or to discuss my care or the status of my bill, they will need to bring a photo ID.

PLEASE PRINT NAMES OF AUTHORIZED INDIVIDUAL(S)

Name

Relationship

Name

Relationship

Name

Relationship

Name

Relationship

Patient Signature

Date

STAFF INIT & DATE _____