Gerard M. Zanolli, MD

5236 California Ave SW Seattle, WA 98136
Phone: 206.938.4200 Fax: 206.938.4201

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: Gerard M. Zanolli, MD

Address: 5236 California Ave SW, Suite B

City: Seattle State: WA Zip Code: 98136

Phone: 206.938.4200 Fax: 206.938.4201

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information

☐ Other: ____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

(**Guardian if minor)**
Patient Signature: ______________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.