BORINQUEN
MEDICAL CENTERS

AUTHORIZATION FOR HEALTH TREATMENT

I hereby authorize Borinquen Medical Centers and its staff (and whomever they may delegate) to provide medical, dental, HIV/AIDS, psychotherapy, nursing, (including local anesthesia and other invasive procedures), emergency, mental health services, substance abuse, out-patient care, telemedicine services or such treatment as necessary.

_______________________________________ _______________________

PATIENT'S NAME **MEDICAL RECORD #**

I hereby authorize Borinquen Medical Centers to release and to receive any and all Medical Records from any provider of health services concerned with past, present or future Medical care necessary for the continuity of my care. It is agreed by all parties that records will be in the strictest confidentiality.

Please understand that all medical and social services records may be released to representatives of the United States Department of Health and Human Services and of programs or projects funded by this department for purposes of determining contract compliance with federal law and regulations. Please refer to BMC: Notice of Privacy Practices.

I hereby certify that I have read and fully understand the above authorization for health treatment and the exchange of medical records.

SIGNED: _____________________________________

DATE: _______________________________________

SIGNED: _____________________________________

(Parent/Guardian Signature for patients under 18)

WITNESSED BY: _______________________________