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, cycle therapy notes, nursing, (including local anesthesia), emergency, mental health services, and out-patient care or such treatment as necessary to:

_____ _____

PATIENT'S NAME **MEDICAL RECORD #**

I hereby authorize Borinquen Medical Centers to release to and receive from any provider of health services concerned with past, present or future medical care, any medical records necessary for the continuity if 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.

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: _____