



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PATIENT ADDRESS: _____

By signing this Authorization, I hereby direct the use or disclosure by Pro Salud Medical Center® (the "Provider") of certain information pertaining to me, my health or my health care as set forth below.

1. The medical information to be released pursuant to this authorization is as follows (provide dates, if applicable):

2. This information may be used or disclosed by Provider to (insert party to which information should be provided):

3. Unless otherwise revoked, this authorization automatically expires on _____ (date or event).
4. The purpose(s) of this use or disclosure is (list all purposes; if the request for disclosure is initiated by the individual, the statement "at the request of the individual" is sufficient):

5. I understand that I have the right at any time to revoke this Authorization pursuant to the Provider's Notice of Privacy Practices, except to the extent that the Provider has already acted in reliance on the Authorization. I understand that I may revoke this Authorization in writing by contacting the Provider.
6. I understand that once the Provider discloses my information, the Provider no longer directly controls the information. It is therefore possible that information disclosed under this Authorization could be redisclosed by the recipient and no longer be subject to privacy protections provided by law.
7. This authorization is voluntary, and I understand that my signing this authorization is not a condition of my care and treatment by the Provider.

Print Individual's Name

Date

**Signature of Individual or
Individual's Personal Representative**

If signed by a Personal Representative, my authority to sign this Authorization and agree to the terms herein exists because I am _____ (describe relationship to individual, or source of authority to sign on individual's behalf).