PEDRO M. ARGUELLO, M.D. PA

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AUTHORIZATIONS

AUTHORIZATION TO DISCLOSED PRIVATE HEALTH INFORMATION

I authorize the release of any information including diagnosis and the records of any treatment of examination rendered to me or dependent to third party payers and/or other practitioners involve in my care.

Signature: _____________________________________ Date:____________________________

I give permission to the following relatives to have access to my protected health information and reserve the right to revoke this at any time by notifying the office in writing.

1.____ Relation:________________________________

2.____ Relation:________________________________

E-mail or Fax Privacy Waiver:

I understand that my medical records may be transmitted electronically by e-mail or fax and, may be received in error by third party. If this should occur, I absolve Pedro M. Arguello, M.D. and his staff. I reserve the right to revoke this at any time by notifying in writing.

Signature:__________________________________

I give authorization to call me and leave me a detail information regarding future appointments to:

Phone #:______________________________ Preferred Language: ______________________________

Signature:_______________________________________ Date:___________________________

Note: This authorization will remain in effect until revoked by patient or legal representative.