# SAN JUAN MEDICAL GROUP, P.C.
# CONSENT FOR RELEASE OF INFORMATION

I, _____, hereby authorize San Juan Medical Group, P.C. to release the following protected health information: Follow-up Appointments, Test Results, or other information at the discretion of my Health Care Provider in the following manner:

Home/Cell or Office Telephone Answering Machines YES or NO

Mail Service YES or NO

Email Service _____ YES or NO

To Authorized Person YES or NO

I hereby authorize San Juan Medical Group, P.C. to release my protected health information to the following person/persons: (i.e. Family, Friends over the age of 18 yrs)

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

I understand that I have the right to revoke this authorization, in writing, at any time to the Privacy Office of San Juan Medical Group, P.C.

Protected Health Information will be limited to Minimum Necessary Standards as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Signature Date

_____

Relationship (if signing for a minor)