AUTHORIZATION FOR HEALTH TREATMENT

☐ I hereby **authorize** Borinquen Medical Centers of Miami-Dade and its staff (and whomever they may delegate) to provide medical, nursing, dental, mental health services, and out-patient care or such treatment as necessary to my child:

☐ I hereby **decline** to have Borinquen Medical Centers of Miami-Dade and its staff (and whomever they may delegate) to provide medical, nursing, dental, mental health services, and out-patient care or such treatment as necessary to my child:

I hereby authorize Borinquen Medical Centers of Miami-Dade 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 of 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.

_____ _____

STUDENT/PATIENT NAME **MEDICAL RECORD #**

PARENT SIGNATURE: _____ **DATE:** _____

WITNESSED BY: _____ **DATE:** _____