MONTES MEDICAL GROUP, INC.

AUTHORIZATION TO ALLOW DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date: _____ Name: _____ DOB: _____

I, _____ authorize the following individual(s) to receive any and all information regarding my medical care. I understand that this authorization will be in effect until revoked by me in writing.

	Name	DOB	Relationship	Driver's License/ State ID Number (optional)
1				
2				
3				

If patient is unable to sign, documentation from legal custodian is required.

Signature of Patient\Legal Custodian: _____

Name of Legal Custodian (if applicable): _____

. The witness must not be an individual named above.

Signature of Witness: _____

Name of Witness: _____

For Montes Medical Group use only:

Name of MMG employee that verified the identity of the patient: _____

Information entered into computer system on _____ (Date) by _____ (Name)