

## AUTHORIZATION

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I, \_\_\_\_\_, do hereby authorize Jose A. Lopez-Cintron, MD to release any medical/billing information to the following people:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

I, \_\_\_\_\_, do not wish to have any of my medical/billing information released to anyone other than myself.

I, \_\_\_\_\_, hereby direct Jose A. Lopez-Cintron, MD to contact me at the numbers listed below:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

I do understand that at any time I can revoke/change any of the above information.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date