SECTION C: Expiration and Revocation

Expiration: This authorization will expire upon the request of the patient

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed bellow. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Oviedo HealthCare – Guillermo Marrero MDPA
Telephone: 407- 971-1970_____ Fax: 407-971-1964_____
E-mail: _____
Address: _____

Inability to Condition Treatment: I understand that Oviedo HealthCare – Guillermo Marrero, MDPA may not condition my treatment on my refusal to sign this authorization.

SIGNATURE – YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include this authorization in the individual's medical record.
Send copy to the Privacy Officer.