LUIS LUGO M.D. INTERNAL
MEDICINE
PORTAL

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

I, ______________________________________(Patient Name), authorize Dr. Luis H. Lugo, M.D. to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named person(s)*

1)____ Relationship _________________________________

2)____ Relationship _________________________________

3)____ Relationship _________________________________

4)____ Relationship _________________________________

I, ____ chose not to release my protected health information.

Please be advised that any person not referred to on this list will not be given any information related to your care, including billing information. You may change, restrict or expand this listing at any time.

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ADVANCE DIRECTIVE

Do you have an Advance Directive/ Living Will? YES_______ NO_____

If yes, please provide us with a copy for our records.

If no, please let us know if you require information.

Xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

AUTHORIZATION FOR PHOTOGRAPHY

I,______________________________________ GRANT CONSENT FOR THE OFFICE OF Luis H. Lugo, M.D. to take pictures of me to be placed in my chart and be used to monitor my health condition. I understand I can revoke this consent at any time in a written and notify the office.

SIGNATURE____ DATE_________________________________