UNIVERSITY OF PUERTO RICO AT MAYAGÜEZ
DEAN OF STUDENTS
HEALTH SERVICES DEPARTMENT
(787) 832-4040, EXTENSIONS 3416, 3408

AUTHORIZATION FOR DIAGNOSIS AND/OR AMBULATORY TREATMENT

Name: _____ Student Number: _____

Date of Birth: _____ Age: ____ Married: ___ Yes ___ No

I authorize the medical staff and personnel determined by the Health Service Department of University of Puerto Rico, Mayaguez Campus to perform the necessary routine diagnostic procedure(s) required by the medical or dental staff for evaluation, and or to give me medical treatment accordance with standard, prevailing medical practice or referral to other health service as needed.

I am aware that medicine is not an exact science, and that I have not been offered guarantees of the result the test(s) and/or treatment(s) to be given.

I hereby certify; (1) that I have read (or have had this read to me) this authorization for the medical procedures considered necessary as judged by medical staff of the Health Service Department of the University of Puerto Rico Mayaguez Campus; (2) that I understood thoroughly all the information given on the form; (3) that before I sign, all the paragraphs that I do not accept or don't apply to my case, have been crossed out.

Date: _____ Time: _____

Patient's Signature: Parent's Guardian's signature:

_____ _____

Public Notary (WITH SEAL)