AUTHORIZATION OF THE USE OF DISCLOSURE OF MEDICAL RECORDS

NAME: ___________________________________ Date of Birth ____/___/_____
(**NOMBRE Y APELLIDO**) (**FECHA DE NACIMIENTO**)

I authorize DMI, LLC officer, employees, agents, contractors, members, director and shareholders or affiliates entrusted with handling medical records for DMI to disclose the transcribed report and other related health care information to:

Yo autorizo a DMI, directores LLC, empleados, agentes, contratistas, socios, accionistas o director y filiales encargadas de la manipulación de los registros médicos de DMI para divulgar el informe transcrito y otra información relacionada con el cuidado de salud para:

1.) Doctor Last Name:____________________ Doctor First Name:________________

Address:____

City:________________________________ State:________ Zip Code:_________________

2.) Doctor Last Name:____________________ Doctor First Name:________________

Address:____

City:________________________________ State:________ Zip Code:_________________

3.) Doctor Last Name:____________________ Doctor First Name:________________

Address:____

City:________________________________ State:________ Zip Code:_________________

The Protected Health Information (P.H.I.) may be used, disclosed or received for the following purpose (s): ____

If you do not wish to describe the purpose, then you may insert: “upon request”
Unless otherwise revoked, this authorization shall retain in effect until: ___________

I acknowledge the following:

1. I have the right to revoke this authorization at any time by sending written notification to DMI, LLC.
2. Any information disclosed pursuant to this authorization to an individual or entity that is not covered by the state and federal privacy laws and regulations may be subject to re-disclosure by the recipient may no longer be protected by federal or state law.

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______________________________________ _____/______/______
Signature / Firma **Date / Fecha**