



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.

Signature / Firma

____/____/____
Date / Fecha