DIAGNOSTIC OUTPATIENT IMAGING

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Phone: 915-881-1900
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Date: ____________________

Patient Name: ____________________

Patient DOB: ____________________

MRN: ____________________

EXAMS

I hereby consent to permit Diagnostic Outpatient Imaging and Outpatient Imaging, PLLC to render medical services for me and provide radiologic consultation on my behalf.

Por medio de Ia presente, concede permiso al Diagnostic Outpatient Imaging and Outpatient Imaging, PLLC, para que me administren los servicios.

INSURANCE PAYMENT

I hereby authorize the release of any medical information necessary to process this claim. I authorize payment directly to the facility for services rendered as described on the claim form. I agree to be responsible for any pending balances on my account.

Autorizo transmitir cualquier informacion medica necesaria para actuar en la peticion de reclamo. Autorizo el pago directo a Ia clinica que presto los servicios detallados en el formulario de reclamo. Sere responsable por cualquier balance de mi cuenta.

MEDICAL RECORDS

I hereby authorize the release of any personal health information and/or medical records necessary to Diagnostic Outpatient Imaging. In the event that I need to revoke this authorization, I understand the revocation will need to be in writing.

Autorizo a Diagnostic Outpatient Imaging que solicite mis archivos medicos si es necesario. En caso the cancelacion de Ia autorizacion entiendo que Ia cancelacion tiene que ser por escrito.

____________________ Signature / Firma

____________________ Date / Fecha