APPLICANT INFORMATION RELEASE

Between: _____

_____

_____

AND **DCO**
 # 49 Calle Muñoz Rivera
Juncos, PR 00777

In connection with application to provide medical services with DCO, I hereby agree as follows:

I hereby authorize any person, educational institution, medical association, State Licensing Board or Company that I have listed in my application form to disclose in good faith any information they may have regarding my qualifications, licensures and fitness for employment. I will hold Company, any former employee, educational institution, State Licensure, Professional Boards and any other person giving reference or information about me free of liability for the exchange of this information and any other reasonable and necessary information pertinent to the employment process.

Provider Candidate	DCO
_____	_____
Authorized Signature	Authorized Signature
_____	Valeria A. Ciccone / Credentialing Officer
Print Name and Title / Date	Print Name and Title