Northwest Diagnostic

Authorization for Disclosure of Confidential Information

(Medical Records Release Form)

Patient Name | Date of Birth | Social Security #

This Authorizes:

Phone: ( ) - Fax: ( ) -

to provide a written or electronic copy, summary or narrative of my medical records (as indicated by the check-mark(s) below) or otherwise release confidential information. I agree that a photocopy of this authorization may be considered valid.

- ☐ Complete record
- ☐ Records of care from the following dates: / / to / /
- ☐ Records of concerning the following conditions:
- ☐ Billing information, visit information
- ☐ Other, please specify:
- ☐ Confer with person(s) listed below orally about my medical information

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, anti-bodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

_____ / /

Patient or Personal Representative Signature | Date

Release the information to:

Northwest Diagnostic Clinic
500 W Whitestone Blvd., Ste. 100
Cedar Park, TX 78613
Phone: (512) 250-3900 Fax: (512) 249-6232

The reasons or purposes for this release of information are as follows:

- ☐ Medical Care
- ☐ Attorney
- ☐ Specialist
- ☐ Other, please specify:
- ☐ Insurance
- ☐ Change of Medical Provider
- ☐ Change of Medical Provider due to Insurance

Patient Signature: _____ Date: / /

I understand that you will provide this information within 30 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners. This authorization expires one year from the date of signature and may be revoked in writing at any time by contacting Northwest Diagnostic Clinic. Information disclosed pursuant to the authorization may be redisclosed by the recipient and no longer protected by the federal privacy regulations.