SOUTHWEST DIAGNOSTIC
IMAGING CENTER

REQUEST FOR RELEASE OF X-RAY FILMS AND/OR REPORTS

- ❑ I hereby request that Southwest Diagnostic Imaging Center release my x-ray films.
- ❑ I hereby request that Southwest Diagnostic Imaging Center release my reports.

Patient name: ______________________________

Previous name: ______________________________

Social Security #: ______________ Date of Birth: ______________

I hereby authorize Southwest Diagnostic Imaging Center, or its representatives, to release for review or photocopying the specific medical information stated below in regards to diagnostic imaging services rendered.

These films/reports are to include:

Examination(s): ______________________________

Date Performed: ______________________________

Patient Name (printed): ______________________________

Please send films/reports to the following address:

Facility name/Physician Office: ______________________________

Street Address: ______________________________

City, State, and Zip: ______________________________

I understand that the information authorized for release may include records of drug or alcohol treatment and the results of AIDS or HIV tests.

This release remains in effect until revoked in writing. A copy of this instrument will have the same validity as the original. Date of this consent will expire no later than two years after the date of this request.

Patient/Guardian signature: ______________________________

Today's Date: ______________________________

File Room Phone: 214-345-8457
File Room Fax: 214-345-4020

4/12/05