SOUTHWEST DIAGNOSTIC IMAGING CENTER

AUTHORIZATION FOR RELEASE OF X-RAY FILMS, REPORTS, AND MEDICAL RECORDS

I hereby request the release of the following x-ray films and/or medical records to Southwest Diagnostic Imaging Center (SWDIC).

Patient name: ______________________________

Previous name (if different): ______________________________

Social Security #: ______________ Date of Birth: ______________

Exam facility name: ______________________________

Street address: ______________________________

City: ______________ State: ________ Zip Code: ________

The purpose of this request is for comparison to previous treatment/surgery/effectiveness or as comparison to recent procedure.

I hereby authorize you to release to Southwest Diagnostic Imaging Center, or its' representatives, for review and photocopying. The specific medical information stated below regarding the past, present, or future physical and/or mental condition and/or any treatment you may have rendered.

Films/medical information requested: ______________________________

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Please send films/reports to the following address:

Southwest Diagnostic Imaging Center
8230 Walnut Hill Lane, Suite 100
Dallas, Texas 75231

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

Mammography patients: If prior films are unobtainable, this exam will become your baseline study.

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

Revised 5/20/03