

AUTHORIZATION FOR RELEASE OF MEDICAL IMAGES, REPORTS, AND MEDICAL RECORDS

Patient Name: _____

Previous Name (If Different): _____ Account Number: _____

Social Security #: _____ Date of Birth: _____

Exam Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Images/Medical Information Requested: _____

- I hereby authorize you to release to Southwest Diagnostic Imaging Center, or its representatives, the following medical images and/or records from the facility listed above. For Mammography requests, please send films.

Please send to the following address: Southwest Diagnostic Imaging Center
8230 Walnut Hill Lane, Suite 100
Dallas, Texas 75231

- I hereby authorize Southwest Diagnostic Imaging Center to release the listed medical images and/or records to the facility listed above.

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

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

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or conditions as follows: _____

Patient or Legally Authorized Representative Signature: _____

Today's Date: _____

File Room Phone: 214-345-8457

File Room Fax: 214-345-4020

Revised 03/05/2009