NEWPORT DIAGNOSTIC CENTER
Authorization for Release of Records

RECORDS REQUESTED

Exam(s)	Date(s) of Service
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________

Report   Images (Online Image Access)

DELIVERY METHOD

******Please PRINT address, fax or email address CLEARLY in the spaces provided below******

Mail ____

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Fax: ____

Encrypted Email: ____

Patient Name: ______________________________ Date of Birth: ____________________

Phone Number: ______________________________

Patient/Guardian Signature: ______________________________ Date: ____________________

Please return signed and dated form as an attachment via email to mr@ndcmail.com or fax to 949/467-3119

***Please note: reports are available 48 hours AFTER the referring physician has received them.*