Excellence, Innovation and Compassionate Care

NEWPORT DIAGNOSTIC CENTER

Authorization for Release of Records

RECORDS REQUESTED

Exam	Date of Service

☐ Report ☐ CD (Images)

☐ I would like to pick up my records (Records available within 24 business hours)

☐ Please mail my records to:

_____

_____

_____

☐ Please fax/email my report to: (emails will be encrypted)

Fax Number: _____ Email: _____

Patient Name: _____ Date of Birth: _____

Phone Number: _____

The first CD copy is provided to you as a courtesy. Please retain for your records.
There will be a $15 charge for additional copies

Patient/Guardian Signature: _____ Date: _____

Please return signed and dated form to mr@ndcmail.com or fax to 949/467-3119. Thank you.