NEWPORT DIAGNOSTIC CENTER
Authorization for Release of Records

RECORDS REQUESTED

Exam(s)	Date(s) of Service

Portal Link Request Report Images (***Online Image Access Link PDF***)

DELIVERY METHOD (Please Choose ONE)

***** PRINT information CLEARLY in the spaces provided below*****

Name of Facility / Physician: ______________________

Mail: Address 1 ______________________

Address 2 ______________________

Fax: ______________________

Encrypted Email: ______________________

Please update email in my chart

Patient Name: ______________________ Date of Birth: ______________

Phone Number: ______________________

Patient/Guardian Signature: ______________________ Date: ______________

Please return SIGNED and dated form as an attachment to:
email: mr@ndcmail.com OR fax: 949/467-3119