SOUTHWEST™
DIAGNOSTIC
IMAGING CENTER

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

You have the right to receive a copy of signed authorizations upon request.

Revised 3/22/18