



I hereby authorize NWDC Imaging Center to disclose the following information from the Imaging records of:

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

This authorization covers patient care rendered from: \_\_\_\_\_ to \_\_\_\_\_ (dates)

Information to be disclosed:

- X-ray Reports/ Films/CD
- DEXA Bone Density Reports
- CT Scan Reports/ Films/CD
- Ultrasound Report/ Films/CD
- MRI/MRA Report/ Films/CD
- Nuclear Medicine Report/ Films/CD
- Other \_\_\_\_\_

This information is to be disclosed to \_\_\_\_\_ for the purpose of \_\_\_\_\_.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability from disclosure of the above information to the extent indicated and authorized herein.

\_\_\_\_\_  
Signature of Patient or Legal Representative Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness Date \_\_\_\_\_