



**NEWPORT
IMAGING
CENTER**

Medical Records Release

This authorization for disclosure of medical information is being requested to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code section 56 et seq. and the HIPAA Privacy Act.

Patient Name: _____ Date of Birth: _____

I hereby authorize Newport Imaging Center to release medical records to:

Name of Physician, Facility or Person; _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

By signing below, I acknowledge receipt of the medical records and accept full responsibility for records released pursuant to this authorization and agree to hold harmless Newport Imaging Center for any action related to the release of these records. I agree to return original X-ray films as soon as possible. I am aware that Newport Imaging Center may be unable to reproduce damaged or misplaced film(s). Records may not be re-released or transferred to another party without authorization by the patient, unless permitted by law.

Signature: _____ Date: _____

If signed by other than the patient, indicate relationship: _____

Witness: _____ Date: _____

ID Checked: _____

<p>For Office Use Only Request form Number: _____ Films to be available for pick-up by: Date: _____ Time: _____</p>
