



- Cypress Station Clinic**
1140 Cypress Station Drive, Houston 77090
- Woodlands Clinic**
9100 Forest Crossing, Suite A
The Woodlands, Texas 77381

**AUTHORIZATION FOR DISCLOSURE OF
CONFIDENTIAL INFORMATION**

Fax for all offices (281) 298-3993

Patient Name _____

Address _____

Date of Birth _____ SSN _____

Authorizes: Name of Person/Facility _____

Address or Fax Number _____

To release the following medical information to **Northwest Diagnostic Clinic, PA**

Check all that may be released:

<input type="checkbox"/> History	<input type="checkbox"/> Physical	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Lab Reports	<input type="checkbox"/> X-ray	<input type="checkbox"/> EKG Report
<input type="checkbox"/> Operative Report	<input type="checkbox"/> Care Plan	<input type="checkbox"/> Therapy Reports
<input type="checkbox"/> Psychological Reports	<input type="checkbox"/> Other (specify) _____	

	<p>Memorial Hermann patients must initial the following statement: "I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information."</p>
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This authorization covers patient care rendered from _____ to _____ (dates)

Purpose of disclosure:

<input type="checkbox"/> Medical Care	<input type="checkbox"/> Attorney	
<input type="checkbox"/> Insurance	<input type="checkbox"/> Other (specify) _____	

This authorization shall be valid for ninety (90) days from the date of signature below, unless revoked in writing by the patient prior to that expiration.

The patient agrees that a photocopy of this authorization may be considered valid.

YES NO

Patient signature: _____ Date: _____

NWDC staff initials/date
