



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

Fax for all offices (281) 298-3993

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name _____

Address _____

Date of Birth _____ SSN _____

authorizes **NORTHWEST DIAGNOSTIC CLINIC, PA** to release the following medical information to:

Name of Person/Facility _____

Address or Fax Number _____

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) _____	

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 one (1) year 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