9201 Pinecroft Drive, Suite 200
Shenandoah, TX 77380

Fax: (281) 651-4818
Email: records@woodlandsdiagnostics.com
Main Office: (281) 863-9554

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name ______________________________

Address ______________________________

Date of Birth ____________ SSN: ____________ Phone: ____________

Email Address ______________________________

Authorized By ☐ Self ☐ Other ______________________________

Facility of Record: ______________________________

I authorize Facility of Record to release the following medical information to **Woodlands Diagnostic Clinic**:

☐ Progress Notes	☐ DEXA Reports	☐ Eye Exam / Retina Scan
☐ Lab Reports	☐ Colonoscopy Reports	☐ Cardiology (EKG|ECHO|Stress)
☐ Immunizations / Vaccines	☐ Imaging Reports	☐ Hospital / Surgical Records
☐ Consult Records	☐ Care Plans	☐ Therapy (PT|Rehab|Home)

☐ Other (specify) ______________________________

☐ Initial — "I acknowledge and hereby consent to such that the released information my contain alcohol, drug abuse, phychiatric, HIV testing, HIV results, or AIDS information."

This authorization covers patient care rendered from __________________ to __________________ (dates).

Purpose of Disclosure:

☐ Medical Care ☐ Insurance ☐ Attorney

☐ 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.

☐ Yes
☐ No

The patient agrees that a photocopy or fascimile of this authorization is considered valid. Further, patient agrees that records may be delivered by postal mail, fax machine, or electronic mail, using the contact information listed at the top of this form.

Patient Signature ______________________________ Date ____________

Parent or Authorized Representative Signature ______________________________ Date ____________