DIAGNOSTIC CLINIC OF LONGVIEW
707 Hollybrook, Longview TX 75605
(903)757-6042 ext 8335 Fax (903)232-8542
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ MRN or Pt ID #_____
Date of Birth: _____/_____/_____ Maiden or Other _____
Address: _____ Telephone # _____
City: _____ State _____ Zip Code _____
DIAGNOSTIC CLINIC PHYSICIAN:_____

Please Check Box for Information that may be Released
Treatment Dates to be Released: _____to_____; or ALL

❑ Billing Records	❑ Immunization Records	❑ X-Ray Reports
❑ Progress Notes	❑ Lab Reports	❑ Mental Health
❑ Consultations	❑ Mammogram Reports	❑ Other (specify)
❑ EKG	❑ Office Procedures	❑ _____
❑ History & Physical	❑ Pap Smear Reports	❑ _____

Transferring Care normally includes last 3 years of all records from designated physician.

PURPOSE OF DISCLOSURE

❑ Continued Medical Care	❑ Personal Use	❑ Insurance
❑ Attorney	❑ Worker's Compensation	❑ Transferring
❑ Other	❑ Clinical Research	

***** Disclosure Format is paper by default. Records are mailed via US Mail after records leave our facility we are no longer responsible. We may charge an additional fee if records are re-requested due to non-receipt.
***** If I have been tested, diagnosed or treated for HIV (AIDS virus) sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.
***** I understand this consent may be revoked in writing at any time by writing to the address above **ATTN: Records Release.**
***** I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
***** Diagnostic Clinic of Longview, will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I hereby request Diagnostic Clinic of Longview to:

❑ **Request** medical information regarding my treatment and care **from**:

Physicians Name: _____ Facility Name:_____
Address: _____City_____ST_____Zip_____
Phone:_____ Fax:_____

❑ **Release** medical information regarding my treatment and care from Dr _____ to:

Physicians Name: _____ Facility Name:_____
Address: _____City:_____ST:_____Zip:_____
Phone:_____ Fax:_____

I understand that I have the right to refuse to sign this authorization.

Patient/Legal Rep_____ Date_____
DL#/identification#_____ Pick Up or Mail
Legal Rep Relationship to Patient_____

THIS AUTHORIZATION EXPIRES 180 DAYS FROM THE DATE SIGNED
DCOL RESERVES THE RIGHT TO ACCESS A FEE FOR COPYING AS SET UP BY THE TSMBE