Excellence, Innovation and Compassionate Care

NEWPORT DIAGNOSTIC CENTER

Authorization for Release of Records

RECORDS REQUESTED

Exam(s)	Date(s) of Service

☐ Report ☐ Images

☐ Mail

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☐ Fax: _____

☐ Encrypted Email: _____

***Please note: reports are available 48 hours AFTER the referring physician has received them.*

Patient Name: _____ Date of Birth: _____

Phone Number: _____

Patient/Guardian Signature: _____ Date: _____

Please return signed and dated form as an attachment via email to mr@ndcmail.com or fax to 949/467-3119