

**NEBRASKA DERMATOLOGY, L.L.C.**

Rex F. Largen, M.D.

5533 South 27<sup>th</sup>, Ste 103

Lincoln NE 68512

Office: (402) 423-7000

FAX: (402) 423-9399

Email: nebraskadermatology@gmail.com

**AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS**

Patient Name (please print): \_\_\_\_\_ D.O.B \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I hereby request and authorize \_\_\_\_\_  
to furnish medical records to:

Physician/Hospital Name: \_\_\_\_\_

Address and/or FAX #: \_\_\_\_\_

Phone #: \_\_\_\_\_

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Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_