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MEDICAL RECORD RELEASE FORM

Phone: (402) 423-7000 Fax: (402) 423-9399

Patient Name (please print): _____

Date of birth: _____

Address: _____

Phone number: _____

THIS WILL AUTHORIZE:

Name of person or organization: _____

Address: _____

Fax number: _____

Phone number: _____

TO RELEASE MEDICAL RECORDS TO:

Name of person or organization: _____

Address: _____

Fax number: _____

Phone number: _____

Patient or legal guardian signature: _____

Date: _____