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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: ______________________