For Office Use Only

Sent: _____

Picked up by: _____

Date: _____

NEBRASKA SPINE + PAIN CENTER

## Authorization for Release of Medical Records

Patient's name _____
Date of birth ____/____/____
Social Security Number _____-___-_____
Address _____
_____
_____
_____
Telephone number (____) ____-_____

Please release my: (Check all that apply)
☐ Medical records (progress notes, operative notes, laboratory test results, diagnostic tests)
☐ X-rays
☐ CD

**FROM:**

☐ Nebraska Spine + Pain Center
13616 California Street, Suite 100
Omaha NE 68154 (402) 496-0404
Fax# (402) 496-7766

☐ Nebraska Spine + Pain Center
6940 Van Dorn Street, Ste 201
Lincoln NE 68506 (402) 323-8484
Fax # (402) 323-8599

www.nebraskaspineandpaincenter.com

**TO:**

_____
_____
_____

**I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.**

_____ _____
Patient's Signature Patient Representative Signature

_____ _____
Print Name Here Print Name Here

_____
Date

**FOR NEBRASKA SPINE + PAIN CENTER USE:**
Received by: _____(Employee/Dept)
MR #: _____ PHYSICIAN: _____