For Office Use Only

Sent: ____________________

Picked up by: ____________________

Date: ____________________

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
Phone: (402) 496-0404
Fax# (402) 496-7766

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: ______________________________

P:\FORMS\WebsitePrintableForms\Authorization for Release of Medical Records.doc
12/27/18