17030 Lakeside Hills Plaza, Suite 102 ● Omaha, NE 68130 ● Phone (402) 758-5800
Fax (402) 758-5809

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:	
Date of Birth:	
Social Security Number:	
Patient Address:	
Telephone Number:	
Purpose for Record Request:	

I hereby request and authorize:

Name:

Address:

Phone #:

Fax #:

to release all my medical record to:

Name:

Address:

Phone #:

Fax #:

I understand the information may include information regarding drug or alcohol abuse, mental health and/or HIV related information. I release the above from all legal responsibility or liability that may arise from the act I have authorized.

I understand that this authorization is valid for one year after the date of my signature. I also understand that this authorization can be revoked, except to the extent that action has already been taken to comply with.

_____ _____

Date Signature of Patient or Legal Representative

_____

Legal Representative's Relationship to Patient