Express Care Clinic/West Lincoln Family Medicine
201 Capitol Beach Boulevard, Suite 1A
Lincoln, NE 68528
Phone: 402-435-0228
Fax: 402-435-0229

Authorization for the Release of Medical Information / Medical Records

Patient Name: _____
Address: _____
_____
_____

Date of Birth: _____ / _____ / _____
Social Security Number: _____ - _____ - _____

I, _____:

Authorize:
□ Express Care Clinic/West Lincoln Family Medicine
□ _____
_____

To release:
□ All medical records / medical information
□ Originals or copies of all radiographs
□ Only the medical records / medical information designated as follows:
_____
_____

To:
□ Express Care Clinic/West Lincoln Family Medicine
201 Capitol Beach Boulevard, Suite 1A
Lincoln, NE 68528
□ _____
_____
_____

The date of this authorization is _____ / _____ / _____ and shall remain in effect until _____ / _____ / _____ (if no ending date is given, it shall remain in effect for on year from the date of authorization).

Patient Signature: _____ Date: _____/ _____ / _____

Authorized Representative (if applicable)
Name: _____
Relationship: _____
Address: _____
_____

This authorization may be revoked by written request by the person signing this authorization.