Barton G. Bellamy D.O.

WILLIAMSBURG FAMILY PHYSICIANS

Taylor Mowinkel, APRN-NP

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Patient's Name: (Printed)

_____

First MI Last

DOB: ____/____/____ Social Security Number: ____-____-____

Address: _____ Phone Number: (____) ___-____

I authorize the health care provider listed below to release the specified information to the organization, agency, or individual named on this request.

Authorized Information Released From:	**Release Information To:**
Clinic:_____	Williamsburg Family Physicians
Dr: _____	6041 Village Drive, Suite 130
Address: _____	Lincoln, NE 68516
Phone:_____	Phone: 402-423-1382
Fax: _____	Fax: 402-423-3590

I authorize the release of the following Sensitive information (check all that apply):

- ☐ Drug abuse (if any)
- ☐ Psychological or psychiatric conditions (if any)
- ☐ Substance abuse (if any)
- ☐ AIDS/HIV (if any)
- ☐ None apply

Please Initial ONE of the following options:

_____ All medical records at this facility

_____ Only records generated by this facility (not including records received from other sources)

_____ Only a portion of the records maintained at facility (specific below)

_____

_____

I UNDERSTAND THAT MY SIGNATURE EXPRESSES AN UNDERSTANDING OF THE CONFIDENTIALITY REQUIREMENTS LISTED ABOVE; I UNDERSTAND THAT THIS CONSENT IS VALID FOR 12 MONTHS, OR I REVOKE IT IN WRITING.

Patient's Name: (Printed) _____

First MI Last

Patient's Signature: _____ Date: _____

Person authorized to sign for Patient (print): _____

Signature: _____ Date: _____