

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

DOB:/	First Social Security Nur	mber: -	MI -	Last
	_		Phone Number: ()	
I authorize the health care pro organization, agency, or indivi	ovider listed below	to release the		
Authorized Information Re	leased From:		Rele	ease Information to:
Williamsburg Family Physicians		Clinic:		
6041 Village Drive, Suite 130		Dr:		
Lincoln, NE 68516		Address:		
Phone: 402-423-1382		Phone:		
Fax: 402-423-3590		Fax:		
□ None apply Please Initial ONE of the follow All medical red Only records a Only a portion	cords at this facility generated by this fac			ds received from other sources) ic below)
I UNDERSTAND THAT MY SIG CONFIDENTIALITY REQUIRE VALID FOR 12 MONTHS, OR I Patient's Name: (Printed)	MENTS LISTED AE I REVOKE IT IN WF	BOVE; I UNDE RITING.	RSTANI	O THAT THIS CONSENT IS
	First		MI	Last
Patient's Signature:		Date:		
Person authorized to sign for F	Patient (print):			
Signature:		Date:		