James P. Devney, DO, PC
9850 Nicholas St., Ste 310
Omaha, NE 68114
Phone: (402) 502-9877
Fax: (402) 905-4855

Authorization to Release Medical Records

Patients Name _____ Date of Birth _____/_____/_____

Address _____
_____
_____
_____

Telephone Number (_____) _____-_____

Please Release the Following:
____ Medical records (progress notes, operative reports, lab results, diagnostic tests)
____ X-rays/MRI/Imaging Reports

From:
James P. Devney, DO, PC
9850 Nicholas St, Ste 310
Omaha, NE 68114

To:
_____
_____
_____
_____

I SPECIFICALLY AUTHORIZE AND CONSENT TO THE DISCLOSURE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

This authorization expires on _____(not to exceed one year); or if no date specified, on the termination of litigation or other proceedings for which this authorization was provided.

_____ _____
Patient's Signature or Patient's Legal Representative Date

_____
Printed Name and Relationship of Patient's Legal Representative

For Office Use Only
Sent: _____
Date:_____