

**CONSENT FOR RELEASE OF INFORMATION**

DATE: \_\_\_\_\_

I hereby authorize: **Kearney Clinic, PC**, 211 West 33rd Street, Kearney, Nebraska  
Business telephone number: 308-865-2141 Business Fax number: 308-865-2150

To release to: \_\_\_\_\_  
Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_ FAX number: \_\_\_\_\_

Records during the period of: Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

I request the following restrictions to the use or disclosure of my health information:

**DO NOT** release to the following persons:  
\_\_\_\_\_

**DO NOT** release my records pertaining to:  
\_\_\_\_\_

Name of Patient	Date of Birth	Social Security #
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Address of Patient**

Phone Number: \_\_\_\_\_

Street, Apt. No. City State Zip Code

This authorization expires: \_\_\_\_\_  
Date

I understand this consent can be revoked at any time except to the extent the disclosure made in good faith has already occurred in reliance on this consent.

The facility, its employees, officers and attending physicians are hereby released from legal responsibility or liability for the release of the above information.

Signed: \_\_\_\_\_  
Patient or Representative

\_\_\_\_\_  
If not Patient, Relationship to Patient

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**If there is more than one person on this request, each person that is 19 years or older need to sign for themselves.**

**\$20 fee due when records are released to the patient. Fee will be waived if records are sent DIRECTLY to another provider.**

**EACH RELEASE TAKES 7-10 WORKING DAYS TO PROCESS**