



Kearney Clinic, P.C.

Kearney Urgent Care

211 West 33rd Street
P.O. Box 670
Kearney, NE 68848
Tel. (308) 865-2141
FAX (308) 865-2150
www.kearneyclinic.com

Family Practice

R. D. Scott, M.D.
M.J. Hanich, M.D.
L.D. Helmick, M.D.
B.D. Rodgers, M.D.
C.C. Jones, M.D.
B.M. Ernst, M.D.
D.A. Sokolowski, M.D.
T.L. Potthoff, M.D.
D.M. Murray, M.D.
T.A. Becker, M.D.
C.S. Murray, M.D.
D.R. Sughrue, F.N.P.-C.

General Surgery

L. E. Bragg, M.D.
W.T. Sorrell, M.D.
J.T. Merz, M.D.
B.J. O'Hare, M.D.
K.D. Koster, P.A.-C.

Vascular and Thoracic Surgery

B. L. Steffen, M.D.

Pediatrics

K. L. Shaffer, M.D.
P.A. Gasseling, M.D.
K.A. Keifer, M.D.
S. L. Greenwald, M.D.
D.K. Psota, M.D.
M. C. Howe, M.D.
S.C. Haskett, M.D.
A.J. Kratochvil-Stava, M.D.

Office Gynecology

C. L. Jensen, M.D.

Clinical Psychology

M. C. Renner, Ph.D.

Mental Health

B.J. Koch, L.M.H.P., L.A.D.C.

Administrator

Peggy K. Dobish

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
Phone: _____

I authorize the Kearney Clinic
to release information to:

Name of Provider or Facility

Address

City, State, Zip Code

Phone # (include area code)

Fax #

OR

I authorize the Kearney Clinic
to obtain information from:

Name of Provider or Facility

Address

City, State, Zip Code

Phone # (include area code)

Fax #

For treatment dates: _____

The following information:

- Records from last _____ year(s),
including Progress notes, lab and x-rays.
- Complete medical record including
progress notes, lab, and x-rays.
- Other: _____

For the following purpose:

- Legal/Insurance
- Patient Request (fee of \$20.00)
- Transfer of Records
Date to be seen _____
- Other (please explain): _____

AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW
I hereby specifically authorize the release of data and information relating to: (check any that apply)

- HIV/AIDS related testing Chemical Dependency (Drug/Alcohol) Mental Health

This authorization will be valid for 180 days from the date that is signed or until _____,
whichever is shorter. This authorization may be revoked at any time by notifying the above named
provider of information in writing, unless this authorization was received as a condition for obtaining
insurance coverage. Any release of information made in compliance with this authorization before my
revocation shall not constitute a breach of my rights to confidentiality. Kearney Clinic and its affiliates do
not condition treatment or payment based on this signature on authorization for disclosure. Information
used/disclosed through this authorization is not longer protected or guaranteed by Kearney Clinic.

Signature of Patient or Legal Guardian
(Parent/Legal Guardian must sign if patient is a minor, NE under age 19)

Date

Relationship to Patient if not the Patient

Patient ID # _____