Michelle Atchison, MD Anne Keating, MD Steven Thom, MD
Nicole Collins, OD Meredith Keeler, OD Maggie Suby Kelly, OD

AUTHORIZATION FOR RELESE OF MEDICAL RECORDS

Patient_____

DOB: _____ SS#: _____Chart#_____

I Authorize:

Eye Consultants of Fargo, PPLC
Attn: Medical Records
3171 44th St S, Ste. 101
Fargo, ND 58101
Fax (701) 235-0330

To Release Records To:

_____
_____
_____

Information to be disclosed:

_____ All Eye Care Records
_____ A-scan/K Readings
_____ Model & Power of IOL
_____ Other_____

_____ Operative Report
_____ Pre/Post LASIK Records
_____ Recent Clinic Visit/Physical

List of people we may release your records to:

_____
_____
_____

_____
Signature of Patient/Guardian/Representative Date

_____
If not a patient, please state authority/relationship

I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance of it. If not previously revoked, this authorization will expire in 12 months.

A photocopy or fax of this authorization will be treated in the same manner as the original.
Records may be faxed to our office at (701) 235-0330. If there are any questions regarding this medical records release, please call our office at (701) 235-0561.