

Michelle Atchison, MD Anne Keating, MD Steven Thom, MD

Nicole Collins, OD Meredith Keeler, OD Maggie Suby-Kelly, OD

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I Authorize: To Release Records To:

*(if release is to self, state “Self”)*

Eye Consultants of North Dakota \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3171 44th St S, Suite 101

Fargo, ND 58104 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax (701) 235-0330

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be disclosed:

\_\_\_\_\_ Any and all records \_\_\_\_\_ Operative Report(s)

\_\_\_\_\_ Billing/Financial Information Only \_\_\_\_\_ Frames/Contact Prescription

\_\_\_\_\_ Records from the following dates: From: \_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Records relating to a specific injury: Specific Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injury Date: \_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Patient / Guardian / Representative Date

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If not patient, please state authority / relationship to patient

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 the medical records release, please call our office at (701)235-0561.