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:

Eye Consultants of North Dakota
3171 44th St S, Suite 101
Fargo, ND 58104
Fax (701) 235-0330

To Release Records To:
(if release is to self, state "Self")

____

____

____

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 ____

____

____   ______________________

Signature of Patient / Guardian / Representative   Date

____

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.