



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

AUTHORIZATION TO RECEIVE MEDICAL RECORDS

Patient: _____ DOB: _____

I Authorize:

To Release Records To:

Eye Consultants of North Dakota
Attn: Medical Records
317144th St. S, Ste. 101
Fargo, ND 58104
Fax (701)235-0330

Information to be disclosed:

- Any and all records
Billing/Financial Information Only
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

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.