VitreoRetinal Surgery, P.A.

Authorization for Release of Medical Records

Requesting Records From:____

____

Patient Name: ____

DOB: ____

Patient Address:____

____

Patient Phone Number: ____

Other Names Used:____

(Maiden name, nickname, etc.)

Please release the following medical records of the patient named above to:_____

____

____

Fax records to (location / fax number):

____

____

___ History & Physical Exam

___ Operative Notes

___ Progress Notes

___ Consultation Reports

___ Pathology, Lab & X-ray

___ Other:_____________

I hereby authorize the release of any information from my exam including diagnostic tests and photographs. This does not authorize re-release of the information to anyone. A photocopy will be treated as the original.

Patient's signature:______________________ Date:___________

EDINA
Minnesota Center
7760 France Ave S, #310
Minneapolis, MN 55435
Phone (952) 929-1131
Fax (952) 929-8873

ST. PAUL
Court International
2550 University Ave W #135N
St. Paul, MN 55114
Phone (651) 644-8993
Fax (651) 644-8994

PLYMOUTH
WestHealth Office Bldg
2855 Campus Drive, #510
Plymouth, MN 55441
Phone (763) 550-1002
Fax (763) 550-1003

OAKDALE
Tessar Professional Bldg
1099 Helmo Ave N, #220
Oakdale, MN 55128
Phone (651) 361-8100
Fax (651) 361-8101

ST. CLOUD
Midsota Center
3701 12th Street N, #102
St. Cloud, MN 56303
Phone (320) 654-8353
Fax (320) 654-8663

BLAINE
11091 Ulysses St NE, #200
Blaine, MN 55434
Phone (763) 235-4104
Fax (763) 755-0277

DULUTH
North Shore Bank Place
4815 W Arrowhead Rd, #210
Hermantown, MN 55811
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