MATTHYS
ORTHOPAEDIC CENTER

Gary A. Matthys, MD
Sean McDonald, PA-C

2301 25th Street South Suite I, Fargo ND 58103
Phone: 701-241-9300 or 866-887-9300
Fax: 701-235-4525

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request / authorize: _____

To release healthcare information of the patient named above to:

Name: _____ Attn: _____

Address: _____

City: _____ State: _____ Zip: _____

Fax: _____ Phone: _____

This request and authorization applies to:

☐ Healthcare information from the following date(s): _____

☐ All healthcare information

☐ Other: _____

☐ Healthcare information relating to the following treatment or condition: _____

_____

Patient Signature: _____

Printed Name: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

For Office Use Only

☐ Verbal Order taken by	Initials _____	Date_____
☐ Records Released.	Initials _____	Date_____
☐ No records available/none released.	Initials _____	Date_____