



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 _____