



Vitreoretinal Surgery, P.A.

Authorization for Release of Medical Records

EDINA

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

ST. PAUL

Central Medical Bldg
393 N Dunlap Street, #
231
St. Paul, MN 55104
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

MINNEAPOLIS

Park Avenue Medical Bldg
710 E 24th Street, Suite
103
Minneapolis, MN 55404
Phone (612) 746-1515
Fax (612) 746-5534

ST. CLOUD

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

DULUTH

North Shore Bank Place
4815 W Arrowhead Rd, # 210
Hermantown, MN 55811
Phone (218) 625-5020
Fax (218) 625-8179

Robert C. Ramsay, MD
Herbert L. Cantrill, MD
Steven R. Bennett, MD
Jill B. Johnson, MD
David F. Williams, MD
Edwin H. Ryan Jr., MD
Sundeep Dev, MD
Robert A. Mitra, MD
Polly A. Quiram, MD
John B. Davies, MD

If calling long distance,
please dial toll free
1-800-635-1797

Requesting Records From: _____

Patient Name: _____

Date of Birth: _____

Patient's Address: _____

Patient's Phone Number: _____

Other Names Used: _____

(Maiden name, nicknames, etc.)

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

Fax records to this 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: _____