



1820 42nd Street South

Grand Forks, ND 58201

Phone Number: 701-775-3151

Fax Number: 701-775-3153

HIPAA Authorization Form

Patient name: (Print) _____

Patient Birthdate: _____

_____ By Initialing this line, I acknowledge that I have received and/or read a copy of the North Dakota Eye Clinic Notice of Privacy Practices.

Emergency Contacts (HIPAA Approved):

Name: _____

Phone: () _____

Relationship: _____

Name: _____

Phone: () _____

Relationship: _____

Name: _____

Phone: () _____

Relationship: _____

Patient Signature: _____

Authorized Signature: _____ Relationship: _____

(If Patient is a minor or incapable of signing)

Today's Date: / / _____