Queen Anne Eye Clinic

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize _____ to release healthcare information

of the patient named above to:

Queen Anne Eye Clinic
20 Boston St
Seattle, WA 98109
Phone: (206) 282-8120
Fax: (206) 282-8046

This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition, or dates:_____

□ All healthcare information

□ Other_____

Patient Signature:_____ Date Signed:_____