# Queen Anne Eye Clinic

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Doctors of Optometry

## 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 Street**
**Seattle, WA 98109**
**Phone/ 206.282.8120**
**Fax/ 206.282.8046**
**E-mail: qaec@qaeye.com**

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates: _____
- Retinal Photos / OCT / Visual Field (email to qaec@qaeye.com)
- All healthcare information
- Other: _____

Patient Signature: _____ Date Signed: _____