Eric J. Bergstrom, OD
Philip Lo, OD
Elizabeth Urbaniak, OD
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 treatment, condition, or dates:

  _____

- ☐ Retinal Photos / OCT / Visual Field (email to qaec@qaeye.com)
- ☐ All healthcare information
- ☐ Other: _____

Patient Signature: _____ Date Signed: _____