authorization to access healthcare information

Patient's Name: _____ Date of Birth: _____

I authorize _____ to access healthcare information

of the patient named above from:

eye clinics of seattle | ballard 2201 NW Market St. Seattle, WA 98109 phone 206.789.7417 fax 206.789.7651	eye clinics of seattle | queen anne 20 Boston St. Seattle, WA 98109 phone 206.282.8120 fax 206.282.8046	eye clinics of seattle | roosevelt 6618 Roosevelt Way NE Seattle, WA 98115 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

□ All healthcare information and billing information

□ Billing information only (can pay bills on patient's behalf)

□ Other_____

Patient Signature:_____ Date Signed:_____

*This form expires 1 year after date of signature