



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

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