

AUTHORIZE TO RELEASE HEALTHCARE INFORMATION

Patient's Name _____ Date of Birth ____/____/____

I request and authorize _____ to release healthcare information of the patient named above **to:**

Optometry Medical Group

Dr. Huy Le Hoang | Dr. Jemimah Corpuz

Rainier Location

3324 Rainier Ave, Seattle WA 98144
P. 206.322.6915 | F. 206.395.2315

Madison Location

1721 22 Ave, Seattle WA 98122
P. 395.2285 | F.395.2329

email: info@omgicansee.com

This request and authorization apply to:

Healthcare information relating to the treatment, condition, or dates:

Retinal Photos/ OTC/ Visual Field (**email to omgicansee.com**)

All healthcare information

Other: _____

Patient Signature _____ Date Signed _____