Shreveport Eye Clinic

318-861-4009

Patient Request to Access Protected Health Information

I, , D.O.B. , authorize The Shreveport Eye Clinic of Shreveport, La. (the "Medical Practice") to provide me with access to my personal health information as indicated below covering **all dates**, for continuation of care:

- ☐ Medical Records
- ☐ Billing Record
- ✓ **All information on me for family member :**

_____

I understand this release is valid until I revoke it in writing.

X_____ DATE:

Signature of Patient or Patient's Authorized Representative

Representative's Name:_____

If not a minor attach Power of Attorney if signed by authorized person.