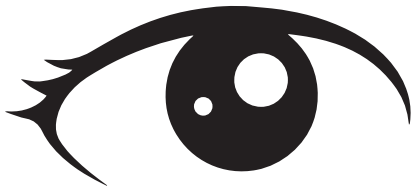

Shreveport Eye Clinic

(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 Records

□ **All information on me for family member:**

_____

I understand this release is valid until I revoke 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.