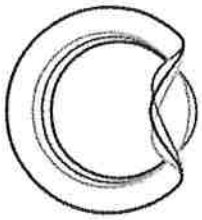

COLUMBIA RIVER
EYE CENTER

Devin Harrison, M.D. ~ Cheryl Lee, M.D. ~ Andrew Chen, M.D.
475 Bradley Blvd. Richland, WA 99352
(509) 943-2240 Fax (509) 943-1575

MEDICARE LIFETIME AUTHORIZATION

TO: Medicare Part B
P.O. Box 6700
Fargo, ND 58108-6700

AUTHORIZATION FROM: _____ **TO: UNTIL REVOKED**

PROVIDER: The Columbia River Eye Center
475 Bradley Blvd
Richland, WA 99352

I request that payment under this medical insurance program be made to the provider named above on any bills for services furnished to me during the effective period of the release to the social security administration or its intermediaries or carriers for any information needed for this claim or any related Medicare claim. I further permit a copy of the authorization to be used in place of the original.

I also appoint the provider or his/her representative as my authorized representative for the purpose of appealing denied claims or refunding inappropriately paid claims.

_____

Patient signature

Patient name _____

Insured name _____

Subscriber's number _____