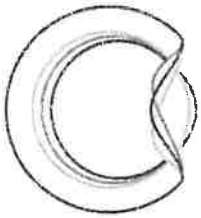

COLUMBIA RIVER
EYE CENTER

Devin Harrison, M.D. ~ Andrew Chen, M.D. ~ Sumit Manhas, O.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

AUTHORIZE FROM: _____ TO: UNTIL REVOKED
(Today's Date)

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 _____

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see a copy of that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or if the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office manager.
By my signature below I acknowledge receipt of the Notice of Policy Practice. This form will be retained in your medical record.

_____ _____
Signature of patient or responsible party Date

I hereby specifically authorize disclosure of my protected health information to the persons indicated below:

Name:_____ Relation:_____

Name:_____ Relation:_____