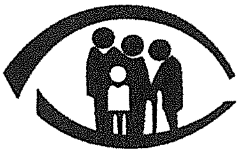

HOPPING EYE ASSOCIATES
LTD, LLP

Ronald L. Hopping, O.D.
Désirée T. Hopping, O.D.
Vissett S. Sun, O.D.
Martin Prati, O.D.

Patient Name ______________________________ Date of Birth ______________________________

I _________________________________ request that all medical records from

____ (Doctor / Clinic Name)

____ (Phone / Fax Number)

For the above patient to be released to:

Hopping Eye Associates ______________________ (Doctor / Clinic Name)

281-488-2020 / 281-488-2009 __________________ (Phone / Fax Number)

____ ______________________

Signature Date

1234 Bay Area Blvd.
Suite E
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