NORTHRIDGE EYE CARE, APC

MEDICAL RECORDS REQUEST

Date: _____

TO: _____
Name of Doctor/Facility

_____
Address

_____ _____
Phone Fax

I, _____, hereby request that my medical records covering the period _____ to _____ be released to:

Northridge Eye Care
530 Main Street
Red Bluff, CA 96080

Tele: (530) 529-1750
Fax: (530) 529-4551

_____
Print Name

_____
Address

_____
Date of Birth

_____
Signature