NORTHRIDGE EYE CARE, APC

530 Main Street
Red Bluff, CA 96080
Tele: (530) 529-1750
Fax: (530) 529-4551

Permission to Release Medical Records

Date: ______________

I, ______________________________, grant permission to Northridge Eye Care to release my personal medical records to ____________________________________.

The medical findings and treatment disclosed should cover the period from ______________ to ______________. In signing this request, I hereby release my Practitioner from any laws governing the disclosure of confidential or privileged information.

____________________________________ Signature of Patient or Legal Guardian

____________________________________ Date of Birth

____________________________________ Printed Name

Name of Facility to Send Records To:

____________________________________ Name

____________________________________ Address

________________ Phone

________________ Fax