Records Request

To: ____

Fax: ____

Phone: ____

I hereby request that my medical records be released to:

North Valley Eye Care

Eye Physicians & Surgeons

Comprehensive Ophthalmology

1700 Bruce Rd.,

Chico, CA 95928

(530) 891-1900

FAX (530) 895-1531

Patient Name: ____

Patient Date of Birth: ____

Patient Signature: ____

Date: ____

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