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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