Records Request

To: ____

Fax: ____

Phone: ____

I hereby request that my medical records be released to:

North Valley Eye Care

Eye Physicians & Surgeons

Comprehensive Ophthalmology

J. Isaac Barthelow, M. D.

Kristiane Ransbarger, M.D.

Anthony J. Rudick, O.D.

Michael Merry, O.D.

Jonathan Mennuccci, O.D.

Craig Montgomery, O.D.

114 Mission Ranch Blvd., Suite 50

Chico, CA 95926

(530) 891-1900

FAX (530) 895-1531

Patient Name: ____

Patient Date of Birth: _____________________________________

Patient Signature: ____

Date: ____

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