

**Records Request**

To: \_\_\_\_\_

Fax: \_\_\_\_\_

Phone: \_\_\_\_\_

I hereby request that my medical records be released to:

***Feather River Eye Care***

Eye Physicians & Surgeons

Comprehensive Ophthalmology

J. Isaac Barthelow, M. D.

Kristiane Ransbarger, M.D.

Anthony J. Rudick, O.D.

Bradley Hamar, O.D.

Jonathan Mennucci, O.D.

Craig Montgomery, O.D.

901 Maple Avenue

Yuba City, CA 95991

(530) 674-8170

FAX (530) 674-5728

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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