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: _____