Northridge Eye Care
530 Main Street
Red Bluff, CA 96080
(530) 529-1750
(530) 435-6074

Medical Records Request

Date:_____

To:_____
Name of Doctor/Facility

_____
Address

_____ _____
Phone Fax

I, _____, hereby request that my medical records covering the

period _____ to _____ be released to Northridge Eye Care.

_____;_____
Print Patient Name Date of Birth

_____
Patient Signature

Office Use:
We are requesting records due to:

_____

_____

_____