Northridge Eye Care, APC

530 Main Street
Red Bluff, CA 96080
Tele: (530) 529-1750
Fax: (530) 529-4551

Permission to Release Medical Records

Date: ______________________________

I, ____, grant permission to Northridge Eye Care to

Release my personal medical records to ______________________________________.

The medical findings and treatment disclosed should cover the period from ______________

to __________________, In signing this request, I hereby release my practitioner from any

laws governing the disclosure of confidential or privileged information.

____
Signature of Patient or Legal Guardian

____
Date of Birth

____
Printed Name

Name of Facility to Send Records to

____
Name

____
Address

____
Phone #

____
Fax#