

Records Request

To: _____

Fax: _____

Phone: _____

I hereby request that my medical records be released to:

Ridge Eye Institute

Eye Physicians & Surgeons

Comprehensive Ophthalmology

J. Isaac Barthelow, M. D.

David Gajda, M.D.

Anthony J. Rudick, O.D.

Ann-Chi Chen, O.D.

Craig Montgomery, O.D.

5889 Clark Road

Paradise, CA 95969

(530) 877-2020

FAX (530) 877-4641

Patient Name: _____

Patient Date of Birth: _____

Patient Signature: _____

Date: _____

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