

Records Request

To: _____

Fax: _____

Phone: _____

I hereby request that my medical records be released to:

Table Mountain Eye Care

Eye Physicians & Surgeons

Comprehensive Ophthalmology

J. Isaac Barthelow, M. D.

Anthony J. Rudick, O.D.

Geoffrey P. Carlson, O.D.

2585 Oro Dam Blvd

Oroville, CA 95966

(530) 922-2020

FAX (530) 922-2021

Patient Name: _____

Patient Date of Birth: _____

Patient Signature: _____

Date: _____

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