<u>Records Request</u>

To: ____

Fax: ____

Phone: ____

I hereby request that my medical records be released to:

Anderson Eye Care

Eye Physicians & Surgeons

Comprehensive Ophthalmology

J. Isaac Barthelow, M. D.

Anthony J. Rudick, O.D.

Joseph Laya, O.D.

2890 Ventura St

Anderson, CA 96007

(530) 365-6471

FAX (530) 365-3332

Patient Name: ____

Patient Date of Birth: ______________________________________

Patient Signature: ____

Date: ____

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