

Records Request

To: _____

Fax: _____

Phone: _____

I hereby request that my medical records be released to:

Willows Eye Care

1070 W. Wood St. Ste. B,

Willows, CA 95988

(530) 934-3373

Patient Name: _____

Patient Date of Birth: _____

Patient Signature: _____

Date: _____

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