

## **Records Request**

To: \_\_\_\_\_

Fax: \_\_\_\_\_

Phone: \_\_\_\_\_

I hereby request that my medical records be released to:

### ***Royo Eye Care***

Eye Physicians & Surgeons

Comprehensive Ophthalmology

J. Isaac Barthelow, M. D.

Adam T. Shupe, O.D.

Baljit Sohal, O.D.

320 H Street, Suite 4

Marysville, CA 95901

(530) 743-1873

FAX (530) 743-1460

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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