

## Records Request

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

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

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

I hereby request that my medical records be released to:

### *Corning Eye Care*

400 Solano St,  
Corning, CA 96021  
(530) 824-2166

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

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

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

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

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