23300 Cinema Dr. Ste 210 Valencia, CA 91355
Phone (661) 287-3939
Fax (661) 287-3838
Email 2020oec@gmail.com

Request for Release of Medical Records:

Patient's FIRST Name: ____

Patient's LAST Name: ____

Patient's Date of Birth: ____________/ _____________/ __________

Dr's Name or Name of Business: _______________________________________

Phone (_______) ____________________________________

Fax (_________) ____________________________________

I____ request the release of my records to

20/20 Optometric Eye Care. Please email my records, retinal images and visual fields to 2020oec@gmail.com as soon as possible.

Thank you.

____
Signature

____
Date

Parent Signature (if under 18) __________________________________