

Records Request

To: _____

Fax: _____

Phone: _____

I hereby request that my medical records be released to:

Cascade Eye Care

Eye Physicians & Surgeons

Comprehensive Ophthalmology

J. Isaac Barthelow, M. D.

Anthony J. Rudick, O.D.

Joseph W. Laya, O.D.

1751 Hartnell Ave Ste.1

Redding, CA 96002

(530) 223-2325

FAX (530) 223-2252

Patient Name: _____

Patient Date of Birth: _____

Patient Signature: _____

Date: _____

CONFIDENTIALITY NOTICE: This message and any attachments may contain confidential health information that is legally privileged. This information is intended for the use of the named recipient(s). The authorized recipient of this information is prohibited from disclosing this information to any party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of this message is strictly prohibited. If you receive this message in error, please notify the sender immediately to arrange disposition of the information. Unintended transmission shall not constitute the waiver of the attorney-client or any other privilege. **HIPAA Reminder:** If you are a "Covered Entity" health care provider as defined in the HIPAA regulation, any emails or electronic files containing Protected Health Information should be encrypted or electronically secured prior to transmission. Updated 4/6/2017 TLG