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(310)391-6311
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REQUEST FOR TRANSFER OF RECORDS

To Doctor:_____

I hereby agree that the above named doctor may disclose any and all information concerning this patient's eye and visual status.

Patient's full name:_____

Current and/or previous address:_____

_____

_____

Date of Birth:_____

Signature:_____

Printed name:_____

Relationship to patient:_____

Date:_____