<u>Records Release</u>

Date _______________

To:____________________

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I, ______________________________, request complete copies of my optometric records to be released to:

Stanislaus Optometric Center, Inc,
4028 Dale Road, Suite 102
Modesto CA, 95356
(*209) 527-5079 Fax*

Thank you,

_________________________________ ________________

Patient Signature Date of Birth