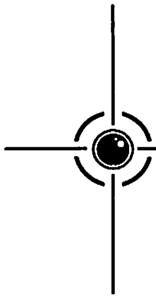

Shawn L. Palmer, M.D.
EYE PHYSICIAN AND SURGEON

Diplomate of American Board of Ophthalmology

Date: ________________________

Dear Dr. Palmer,

Please transfer my medical records to the name and address listed below.

Name: ____

Address: ____

City: ____

Ph: ____

Fax: ____

Thank you for your prompt attention to this request.

Name of Patient: ____

Date of Birth: ____

Signature: ____

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