Date: _____

Dear Dr. _____
Address: _____
Ph: _____
Fax: _____

Please send my medical records to the following office: Include all Visual Fields or other testing and any contact lens information that may be included.

Shawn L. Palmer, M.D.
2160 East Bidwell Street
Folsom, CA 95630
916 983-9823
916-983-9623 fax

Name: _____

Date of Birth: _____

Signed: _____