

**Richard R. Rigsby, O.D.**  
**Carole L. Rigsby, O.D.**  
**15126 San Pedro, US 281 N**  
**San Antonio, TX 78232**  
**210/494-7687**  
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Date: \_\_\_\_\_

To: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone / fax \_\_\_\_\_

**Records Transfer Request**

I authorize the release of my eye care records, or copies of such, including visual fields and other testing, to Drs. Richard or Carole Rigsby

Patient's name (print) \_\_\_\_\_

Date of birth \_\_\_\_\_

Signature \_\_\_\_\_

Witness \_\_\_\_\_