

David M. Feinstein, M.D., FACP, FRCP ©
Diabetes · Endocrinology · Osteoporosis
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Date: _____

I hereby authorize David M. Feinstein, M.D. to release or to receive my medical records to or from the following person. Please list name of Doctor with their address and phone/fax number.

Please mark the records you are needing us to release:

___ Office Notes ___ Scans/X-Rays ___ Bone density
___ Lab Work ___ Most Recent Visit ___ All Medical Records

Patient Signature

Print Patient Name

Patient's Date of Birth

Patient's Social Security Number

We appreciate your time in filling out the following:

- **Do you intend to continue your care with Dr. Feinstein?** Yes _____ No _____
- **Did Dr. Feinstein refer you to see this doctor?** Yes _____ No _____
- **Reason for transfer:**
 - ___ 1. Change of insurance.
 - ___ 2. Dissatisfaction with Dr.
 - ___ 3. Dissatisfaction with office.
 - ___ 4. Other. Please explain:

*****There is a fee of \$25.00 for your records, unless you just want the last office visit at no charge.**