

**David M. Feinstein, M. D., FACP, FRCP**  
Diplomate American Board of Endocrinology and Metabolism  
7777 Forest Lane C-604 Dallas Texas 75230  
972-566-4888 972-566-4539 Fax

## **Medical Records Release**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient's Birth Date: \_\_\_\_\_

Patient's Social Security Number: \_\_\_\_\_

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

I hereby authorize you to release any and all medical records including diagnosis and treatment rendered to me. Please release to:

David M. Feinstein, M.D.  
7777 Forest Lane C604  
Dallas, Texas 75230  
972-566-4888 Fax: 972-566-4539

Thank you for your help.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Print Patient's Name