

**David M. Feinstein, M. D., FACP, FRCP**  
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5232 Forest Lane #170, Dallas, TX 75244  
214-964-0888 phone  
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## **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.  
5232 Forest Lane #170  
Dallas, Texas 75244  
Phone: 214-964-0888 Fax: 214-484-1718

Thank you for your help.

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

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