Dr. Jeffrey S. Feldman *Specialist in Pediatrics*

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Caring for Kids
Guiding Families

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO DR. FELDMAN

PATIENT NAME: ____ _______DOB: ______________________

PATIENT NAME: ____ _______DOB: ______________________

PATIENT NAME: ____ _______DOB: ______________________

Address ____

Phone Numbers for: (PRINT NAME) ____

Home # ______________________________ Work #_____________________________Cell # _____________________________

____ ____________OR ____
PARENT/GUARDIAN SIGNATURE PATIENT'S SIGNATURE

____ ____
PRINT NAME AND RELATIONSHIP TO PATIENT DATE

PLEASE FAX the following to 781- 662- 4585:
Most recent Well visit, Immunization Record, Growth chart, Problem List, Med List, Birth Record, any pertinent labs.

If you prefer, mail them to: Jeffrey S. Feldman, MD
340 Main Street, Suite 101
Melrose, MA 02176