



# SCHLESSINGER EYE & FACE

AESTHETIC EYELID SURGERY · FACIAL REJUVENATION

SPECIALIZING IN OPHTHALMIC PLASTIC SURGERY

## RECORDS RELEASE REQUEST

Re: Patient \_\_\_\_\_

Doctor:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize the release of my medical records  
and request that they be forwarded to:

**David A. Schlessinger, M.D.**

**75 Froehlich Farm Blvd.**

**Woodbury, New York 11797**

**516-496-2122 -P**

**516-496-2201 -F**

Patient Contact Informaton:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number and Date of Birth

Patient Signature: \_\_\_\_\_

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