**Lederman and Lederman, LLP**
**Pediatric Ophthalmology**
**Strabismus**

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Website: www.ChildrensEyeMD.com
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Date: _____

Dear Dr. _____

Telephone #: _____

Fax #: _____

Kindly send Records Concerning:

Patient's Name: _____

Patient's Address: _____

_____

Patient's Date of Birth: _____

To:

Martin E. Lederman, M.D.
Carolyn R. Lederman, M.D.
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Purchase, New York 10577

Sincerely,

_____
Signature of Patient, Parent, or Legal Guardian

_____
Print Name