

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

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Telephone (914) 417-6441
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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.
Gennifer J. Greebel, M.D.
Darron A. Bacal, M.D.
3020 Westchester Avenue, Suite 201
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Sincerely,

Signature of Patient, Parent, or Legal Guardian

Print Name