

**Endocrinology**

Paul Denker, M.D.

**Rheumatology**

Karen Zagar, M.D.  
Tatiana Nagibina, M.D.

**Internal Medicine**

Hans Langschwager, M.D.

**MEDICAL RELEASE OF INFORMATION**

Date \_\_\_\_\_

Print Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Signature \_\_\_\_\_ Social Security Number(last four) \_\_\_\_\_

TO \_\_\_\_\_

FAX \_\_\_\_\_ PHONE \_\_\_\_\_

I hereby authorize and request you to release any and all information which you may possess relating to my examination and illnesses, including psychiatric and/or psychological information which may be part of my records.

SPECIAL ATTENTION TO:

OFFICE NOTES \_\_\_\_\_

LABORATORY AND BIOPSY REPORTS \_\_\_\_\_

IMAGING : XRAY \_\_\_\_\_ MRI \_\_\_\_\_ CT \_\_\_\_\_ DEXA \_\_\_\_\_

SPECIAL NOTE: \_\_\_\_\_

**Please forward using this page as your coversheet to:**

32615 US HWY 19N

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Palm Harbor, FL 34684

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Phone (727) 789-2784 Attn: \_\_\_\_\_

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