ARTHRITIS & DIABETES CENTER

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 <u>using this page as your coversheet</u> to:

32615 US HWY 19N
Suite 2
Palm Harbor, FL 34684
Fax (727) 785-3537
Phone (727) 789-2784 Attn: _____

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