www.NozDoc.com (Nose-Doc)

Roger N. Danziger, M.D. P.A.
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****ATTENTION** If you are sending requested medical papers **If more than 10 pages Please Mail Thank you****

Authorization to release Medical Records

I hereby authorize the following health care providers to release my medical records to Roger N. Danziger, M.D. P.A.

_____

_____

_____

I hereby authorize Roger N. Danziger, M.D. P.A. to release my medical records to:

_____

Information requested:

____ **Skin Test Results**	_____ **Injection Record**	_____ **Lab Work**
____ **Sinus / Chest CT Report**	_____ **PFT Results**	_____
____ **Sinus / Chest X-Ray Report**	_____ **Office Notes**	_____

I understand the transfer of my records will be used only for my personal medical treatment. I understand that my medical records will not be disclosed to any third parties. I understand that my medical records can also be shared with my health insurance company.

Patient Name: _____ DOB: _____
(print)

Signature: _____ Date: _____

Parent or legal guardian if patient is a minor: _____
(print)

Signature of parent/legal guardian of minor: _____Date: _____