

www.NozDoc.com (Nose-Doc)

www.ManateeAllergy.com

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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: _____ (print) DOB: _____

Signature: _____ Date: _____

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

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