The NON-SURGICAL CENTER OF TEXAS
SPORTS • SPINE • ORTHOPEDICS
Annette M. Zaharoff, M.D.

I, _____, here by request that Annette M. Zaharoff, M.D. release to:

Name: _____

Phone: _____

Email: _____

Address: _____

_____

A report of my diagnosis, treatment, prognosis, and recommendations. As well as other data (Including lab reports, x-rays, etc) pertinent to my treatment at The Non-Surgical Center of Texas.

_____ _____
Signature Date

_____
Date of Birth

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