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Authorization for Release of Records

I _____ (Patient) authorize Dr. Howard's office to release my medical records to the following address:

Phone: _____

FAX: _____

To furnish a copy of ___all or ___Operative Report(s) medical records covering from the following time frame: _____ .

Please send the medical records to the above address or fax number (Photos cannot be faxed). I release you from all legal responsibility that may arise from this authorization.

Signed: _____ DATE: _____

Confidentiality Notice:

This information is privileged and confidential information and intended only for the use of the individual or entity named in the address. If you are not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is strictly prohibited. If you received this in error, please notify the sender and destroy this information and retain no copies.