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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: _____