## Robert Howe MD, PC

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## **Authorization for Release of Records**

Please send a copy of this release with the request records.

Request copies of medical record			Review medical record		
PATIENT INFO	RMATION (please print)				
Patient Name:				Date of Birth://	
Address:			Home Phone:		
City:	State:	_ Zip:	Cell	Cell Phone:	
RELEASE OF IN	FORMATION				
I hereby Authorize	Robert Howe MD, PC to:				
[ ] Obtain my med	lical records from:	[ ] Release	my medical reco	rds to:	
Physician/Facility:					
Address:	Address:		Phor	Phone:	
City:	State:	Zip:	Fax:		
Reason: [	] Change of insurance ] Moving out of area ] Other:	[ ] Transfer [ ] Speciali	of care st consultation	[ ] Personal file	
	Chapter 135 of the Acts of 2003, "An A he right to charge a reasonable fee for t	_		ŭ	
INFORMATION	TO BE RELEASED				
[ ] All	[ ] Last three visits	[ ]	Last Annual/Pap	& Mammogram	
[ ] Infertility Only	y [ ] Last two years	[ ]			
CONSENT					
I authorize the rele	ease of all information indicate	ted, and I am a	ware that the rec	ords released may contain	
information relatin	g to psychiatric or psycholog	gical testing, p	•	•	
			Yes No		
I authorize the release of HIV/HTLV/AIDS test results.					
I understand that I	may be charged for copies p	rovided.			
Signature of Patient	or Patient's Representative		Date		

<sup>\*</sup>This consent is only valid for 90 days. It may be revoked by the signer at any time, except to the extent that Robert Howe MD, PC has completed action on it.