



Comprehensive Care
Rheumatology • Naturopathy • Acupuncture • Yoga Therapy

Patient Name: _____ DOB: _____

I authorize: _____

To release a copy of my medical records to: Dr. Paul Howard, MD
 Audrey Bressor, ANP
 Matt Mustain, PA-C
 Dr. Leslie Axelrod, NMD
 Dr. Keith Wilkinson, NMD
(address below)

For the purpose of: _____

Please disclose medical records from (date) _____ to _____

Including: Lab X-Ray Office Notes H&P

If applicable, the undersigned further authorizes his/her doctor to disclose a copy of records pertaining to:

- 1) Testing and/or treatment for AIDS and AIDS related diseases
- 2) Treatment of psychiatric illness
- 3) Treatment for drug and or alcohol abuse

Signature of Patient/Guardian _____ Date _____

Address _____

City _____ State _____ Zip _____

Expiration of this release of authorization is 3 months from the above signed date.